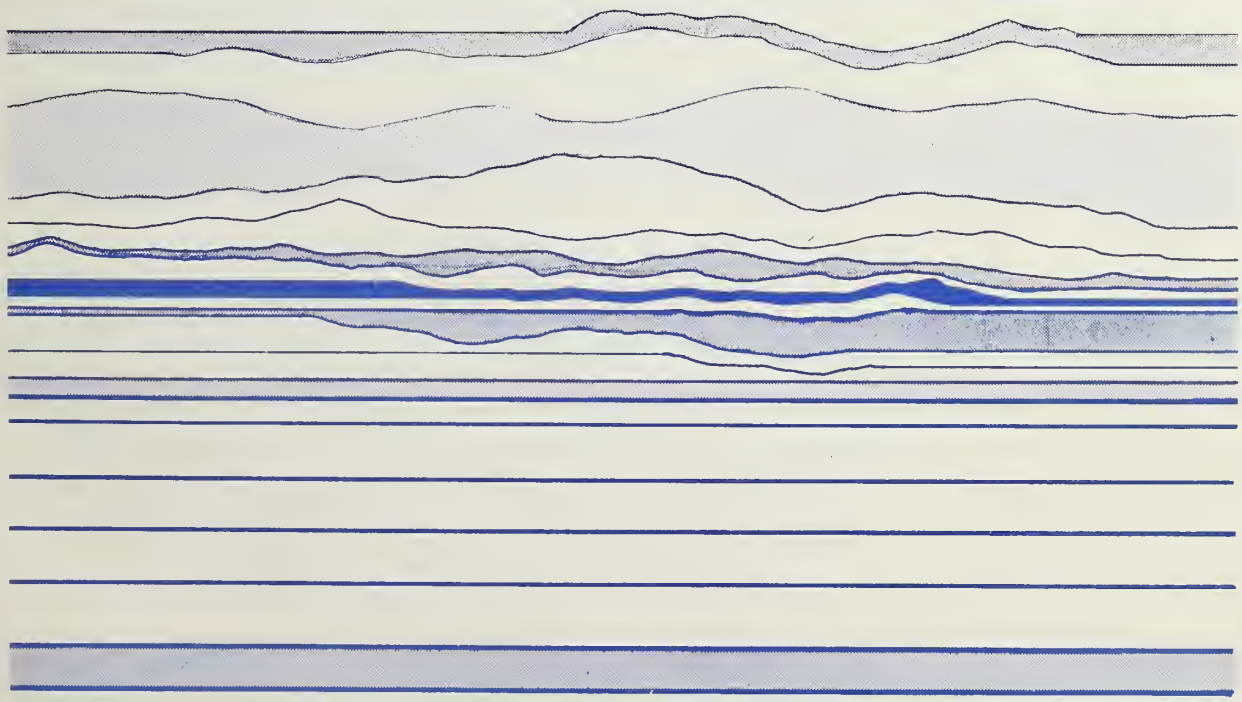
Illinois Department of Public Aid
Edward T. Duffy, Director

1986:
LONG TERM CARE RESEARCH AND DEMONSTRATION PROJECTS
FINAL REPORTS



NEW HORIZONS IN LONG TERM CARE

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Funds for collaborative research in long term care were appropriated in the Department of Public Aid's budget in Fiscal Year 1986 to find new ways to treat long term care patients in Illinois nursing homes. The $1.25 million appropriation enabled the State, academic institutions, and providers of long term care to pool their talents for the first time. In all, there were 17 projects funded in Fiscal Year 1986. The attached document is the final report from one of those projects.

The Department of Public Aid expects the ideas generated by these projects to be put into reality. There are, in fact, training programs already being disseminated as a result of the research.

This report is one of a series of reports that comprise the long term care projects funded during 1986. Copies of the other reports are available from the Department of Public Aid by writing to Jo Ann Day, Ph.D., Long Term Care Research and Demonstration Project Director, Office for Employment and Social Services.

Edward T. Duffy

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EXEMPLARS OF QUALITY:
THE PATHS TO EXCELLENCE IN
QUALITY NURSING HOMES

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EXEMPLARS OF QUALITY:

PATHS TO EXCELLENCE IN QUALITY NURSING HOMES

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ACKNOWLEDGEMENTS

This project has been a gratifying experience. We studied some preeminent nursing homes in Illinois to see how they achieve excellence. We are pleased with what we found. And we are particularly happy with the friends we made along the way.

The Illinois Association of Homes for the Aging sponsored and directed the project. It was funded by the Illinois Department of Public Aid.

As authors of this report, we bear the full responsibility for the design of the project, the collection of the data, its analysis and the conclusions. However, the project would have floundered without the active cooperation and goodwill of numerous parties.

In the first place, and most importantly, our sincere thanks go to the eight nursing homes who hold the center stage in this study. We could not have asked for more than the wholehearted and warm cooperation we received at these homes, from the administrators, the directors of nursing and the directors of departments down to the nurse's aides. They were true to their character, they proved to be real stars also in the courtesy, kindness and cooperation they extended to us.

The Illinois Department of Public Aid funded this project. But their generosity went beyond the call of duty. They opened to us their files, they responded to our endless inquiries, and they did all this with a geniality and openness uncharacteristic of state departments. Above all, they provided information to us with a no-holds-barred approach and with no assurance that our conclusions would tilt in their favor. We feel obliged to acknowledge with special gratitude the cooperation of Ms. Connie Eaton Cheren, Ms. Mary Gober and Dr. Jo Ann Day.

Ms. Tess Kwiatkowski, the Acting Director of the Illinois Association of the Homes for the Aging, served as the Associate Project Director and then the Project Director of this study. In charm, graciousness and cooperation no one could expect anything more than what Ms. Kwiatkowski gave to the project.

Ms. Jan Sonnenberg served as the nurse researcher on this project. She was indefatigable in her effort and imaginative in her pursuit of the data. We reserve our special gratitude to her.

Numerous others gave of their time and expertise to this project. We extend to them our heartfelt thanks.

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October 15, 1986

INTRODUCTION

Both the experts and the public bemoan that our nursing homes have become the settling tanks for our frail elderly. President Nixon in a major speech in 1971 castigated the nation's nursing homes for their disgraceful conditions. With his customary zeal Ralph Nader has railed against nursing homes. The U.S. Senate Special Committee on Aging concluded in a recent study that a third of the nation's skilled nursing facilities fail to meet the essential standards for health, safety and quality of care.[1] The New York Times reflected on that study and charged that our elderly are rotting in the warehouses we call nursing homes.[2] Then, of course, there is "Amos" in which Kirk Douglas dramatizes the failure of American nursing homes.

These castigations may have served well in prodding the nation's conscience. Yet, at the same time, they may also have unnecessarily tarred the extraordinary record of many nursing homes that continue to care for our elderly with love, dignity and professionalism.

There indeed exist such exemplars of excellence, and you don't look for them only on the gold coasts of America. Excellence in nursing home care transcends all lines: you find excellence in nursing homes which predominantly serve the indigent elderly; you find it in those with different religious persuasions and varied profit motives.

These unsung models of exemplary care to our elderly deserve to be recognized and applauded. Theirs is a success story little known and barely appreciated. Heroes and saints may be hard to come by, but their achievements uplift and inspire the mediocre. They can also teach and persuade, for they have successfully broken out of the beaten path; they have pursued the highroad; they have achieved excellence.

The purpose of this study was not so much to applaud their success, but to understand how the best nursing homes achieve a high quality of care. In an otherwise besmirched story of the nursing home industry, the superior homes bear inspiring witness that quality is not beyond reach. The paths to it may be different, but they are by no means hidden or mysterious. This study was

designed with the assumption that it would benefit the public and the provider community if we can chart the course the best nursing homes follow, if we can understand the strategies they pursue and if we can explain how judiciously they invest their resources in order to achieve the goal.

Our study was based in Illinois. We gathered and analyzed extensive industry-wide data. But to achieve a neater and sharper focus, our analysis drew mostly on eight case studies in the state. We investigated these eight successful nursing homes through on-site investigation, interviews and the analysis of documents and other sources. Our discussion of what is quality, and what routes lead to it, revolves around the tale these homes have to tell.

The character of nursing homes in Illinois is diverse and our sample reflects their variety: proprietary, not-for-profit and county run; Catholic, Jewish and Protestant, including one of fundamentalist persuasion; and differences in size, resident-mix and locations around the state. Although long-term care facilities for the developmentally disabled were initially considered, the final group we chose to focus on consists only of nursing homes for the aging.

Our intent was to find out how the better homes operate and marshall their resources to achieve their goal. We did not go into homes to determine the level and quality of their care. Evaluation of standards is a complex process both in conception and in practice. That task was beyond the intent of this study, and for good reason; both federal and state agencies conduct multiple and periodic inspections of care.

Given our purpose, we followed the least problematic route for identifying the better nursing homes in Illinois. The Illinois Department of Public Aid has recently initiated a unique and well regarded quality incentive program (QUIP) for long-term care facilities; it both measures quality and rewards high performers. We selected a sample of those homes that achieved six-star awards, the highest accorded, in QUIP's 1985 surveys. Additionally, we investigated their record with the Illinois Department of Health as well as with the federal agencies. The results were consistent across all fronts; all agreed that the group we selected indeed constituted superior examples in the industry.

There is, then, another side to the nursing home story, and this study explores its meaning. It looks at the unsung stars among nursing homes in Illinois and asks how they achieve their level of excellence. What is their secret? Given the constraints they share with others, what makes them rise above the crowd? What is their recipe for success? What lessons do they hold for their brethren that lag behind? The answers to these quesions are revealing, and they are, we found, quite in line with the findings and discussions in the literature. Achievement of good nursing home care, in other words, is neither an unattainable task, nor is it an elusive and esoteric enterprise, as the eight case studies in Illinois bear witness.

Our investigations resulted in a fuller report which we have presented in its entirety to the Illinois Department of Public Aid. The present account, however, offers only a summary of that larger report. Section I briefly summarizes the four chapters in the original version which discussed the notion of quality. Chapter 5 in Section II sketches in broad strokes the profile of the eight homes that hold the limelight in this study. The six chapters in Section III highlight the major strategies superior nursing homes pursue in attaining high quality. These last chapters appear largely intact as in the original version.

SECTION I

WHAT IS QUALITY OF CARE IN A NURSING HOME?

The story of the successful nursing homes in Illinois deserves to be told. It is a tale rich in detail and human interest. However, our purpose here is not to regale, nor to impress; it is to inform and to enlighten. Nursing homes that have risen above mediocrity have valuable experiences to share and important lessons to teach; for, they have faced common challenges and bear common scars. We intend to highlight the common themes in their efforts to achieve quality, and to illuminate the common strategies that have brought them success.

We will better understand these winning strategies if we first face the question: What is quality of care in the nursing home context? We address this question briefly in the four chapters in this section.

Chapter 1 considers quality of care in its practical setting. Care providers and regulators face two hard dilemmas: the institutional dilemma and the bureaucratic dilemma.

Chapter 2 looks at the systemic flaw in long-term care, a flaw the nursing home industry has inherited from its uneven and checkered history.

Chapter 3 points to the role regulation has played in promoting quality in nursing homes. Public policy may have hobbled along, but regulation has succeeded in nudging the industry in the right direction.

Chapter 4 sketches the achievement of state regulation in Illinois. In the larger view, Illinois stands in respectable company.

As we noted in the Introduction, these four chapters appear here in a condensed form. The full version was included in the report we submitted to the Illinois Department of Public Aid.

CHAPTER 1

QUALITY OF CARE: PERSISTENT DILEMMAS AND HARD CHOICES

A Summary

What is quality of life in a nursing home? The answer is simple and commonsensical: you have high quality when the resident is satisfied—with oneself, with the nursing home and with the care one receives; quality of life means that the resident achieves one's goals and remains in control of one's life.[3] But how do you translate this uncomplicated concept in a complex institutional setting?

Consider the two dilemmas and trade-offs care providers face: a) the institutional dilemma, and b) the bureaucratic delimma.

A. Quality of Care: The Institutional Dilemma

If you are a care provider, life in an institution forces on you three trade-offs.

- A nursing home has a life of its own. You are required to serve diverse residents and to meet different needs. So what happens to order and efficiency if you encourage individuality, promote privacy and foster self-care?[4]

- An institution has to respond to external forces. You would like to favor the resident's independence, self-determination and personal choice. In so doing you may risk liability, fall foul of the insurance company and create for yourself problems of safety and order.[5]

- Should professional judgment prevail over the right of the resident? Mr. Mikulich is very old, mildly demented and declines to eat. Should you force-feed him with a nasogastric tube?

A nursing home is driven by an institutional logic. It defines quality on its own terms. Excellent homes meet this institutional challenge with admirable good judgment. The mediocre ones succumb to the organizational temptation: they favor order, they prefer less risk, they are excessively prudent. Regimentation, manipulation, meaningless activities and empty rituals are, unfortunately, the common organizational sin.

B. Quality of Care: The Bureaucratic Dilemma

Care providers and regulators alike are caught in a dilemma as American life drifts more and more towards legalism and bureaucratization. We are increasingly a society of laws; bureaucracy is the handmaiden of such a society.

- The tide of legalism has spawned a multitude of specialists in nursing home care. It has parcelled out care into unrealistic compartments; it has produced a breed of academics who endlessly measure quality; it has produced agencies who love to formulate, evaluate and enforce standards.

- The soul of bureaucracy is precise codes, legal formulation, uniform standards and technical compliance. Government sets standards in excruciating detail, devoid though they sometimes be of the commonsensical, human, workaday reality.

- Our very thinking is colored by the regulatory logic. When some nursing home providers toured Sweden in 1985, they were impressed by the Swedish nursing homes—their home-like setting, their high quality care, their little concern with costs. Yet, the Americans were struck that Swedish homes may routinely violate the American code![7]

- Far too many nursing homes have learned to adapt to a regulatory climate. Their care is good, although it lacks the soul; they follow the correct procedures, but forget the caring touch. They leave no evidence upon which legal action may be taken. How do you measure staff apathy and the resident's emotional decline?

What is quality of care within institutional limits, and how does one formulate, evaluate and enforce it in a legalistic culture? These questions force hard choices both on care providers and on state regulators. It is illuminating to see how superior nursing homes bring an imagination and art to the task at hand; they follow innovative paths and succeed in delivering excellent care to our elderly.

CHAPTER 2

QUALITY OF CARE: THE BURDEN OF HISTORY

A Summary

The American experience in long-term care is unique in western history. The problem of quality appears endemic to the nursing home industry, partly because the industry has developed haphazardly and has inherited a systemic flaw. Ponder four of its features.

A. Long-Term Care: An Uncertain Mandate

Public policy towards nursing homes has developed fitfully and irregularly. It has provided nursing homes no central direction and no clear mission.

- In the 1920s about 0.6 percent of the elderly lived in poorhouses[8] and about the same number in charitable homes; but they were found mostly in mental hospitals.

- The 1935 Social Security Act spurred the nursing home growth, but by a legal quirk it enabled proprietaries to gain a strong foothold in the market. The post-World War II legislation further helped the growth of nursing homes.

- The Medicare and Medicaid legislation of the 1960s favored the hospitals and gave them little incentive to provide long-term care. As a result, free-standing nursing homes mushroomed across the nation.

- In the 1970s as patients left mental hospitals, they came in droves to the nursing homes.

- In the mid 1980s the DRG-based payment system sent to the nursing homes yet another subpopulation, the subacute care patients.

Through this patchy history then, has emerged the nursing home of today with its difficult mission to serve society's residual groups, the frail elderly, the poor, the alcoholics, the mentally impaired and those the hospitals discharge quicker and sicker.

B. Long-Term Care: Separate and Unequal

The U. S. health care system runs on two tracks—separate, distinct and unequal.

- Acute care still reigns supreme in the health care field. It draws disproportionately on the health care dollar—in reimbursement, research, education and technology.

- In England geriatrics is a medical specialty. However, in the U. S., "Medicare supports graduate medical education at $2 billion a year . . . , but nothing goes to develop the academic leadership that will put geriatrics in the mainstream of primary and specialty medicine."[9]

C. The Dubious Commitment

The national commitment to the care of our seniors remains indifferent at best.

- In Denmark it is illegal to operate a nursing home for profit. No new nursing homes will be built after 1986. Helping to keep the seniors in their

homes is the centerpiece of Danish policy.[10]

- In the U. S. Medicare spends less than 2 percent of its budget on nursing homes. Insurance companies have also kept nursing homes at arm's length.

- Medicaid picks up over 40 percent of the tab. But nursing homes tirelessly point out that most states spend near twice as much a day on a prisoner, than on a nursing home resident.

D. Setting the Standards with the Profit Motive

Seven in ten nursing homes in the nation, constituting 80 percent of the beds, are run for profit—a unique situation in the western world.

- Researchers argue that profitability and quality are antithetical.[11,12] To get the highest return on the investment, you scrimp on labor, which drains 60 percent of the operating budget; you give fewer rewards and therefore attract mediocre talent; you staff at the bare minimum required by regulation.[13]

- The proprietaries emerged on the scene in the mid 1960s attracted by easy mortgage loans. The new speculator made hefty returns on thin capitalization. When regulation and reimbursement reform slowed the market, the early speculators left the industry.

- Investor-owned chains now carry on the proprietary impetus. Beverly Enterprises, the superstar of the industry, now owns 8 percent of all nursing home beds, and foresees that it will capture 15 percent of them by the mid 1990s.[14,15]

What is the record of the proprietary homes? Bruce Vladeck has summarized a general consensus: "On the average, voluntary facilities are somewhat better than proprietary ones. The best voluntary ones are the best

there are. The worst nursing homes are almost exclusively proprietary. But in the middle range there is substantial overlap."[16]

In sum, you will appreciate how the best nursing homes achieve quality, if you understand the severe burden of a checkered history they labor under.

CHAPTER 3

QUALITY OF CARE: THE ROLE OF REGULATION

A Summary

One cannot simple-mindedly scoff at nursing home regulation because it falls short of the ideal. You should rather ask how regulation has improved the life in the nursing home, given the gyrations that a democratic government has to go through.

A. The Problem of State Regulation

If regulation has not eliminated the scandal from the industry, it is due less to a lack of will than to the barriers that can frustrate that will.

- The principle of federalism gives the states a discretion in setting standards. Individual states respond to local pressures. That has resulted in a wide variation in standards that govern nursing homes.

- Law and patronage fragment responsibility among agencies. One agency holds no authority over another. Thus, accountability can fall between the cracks.

- Verifiable, measurable and uniform criteria are the soul of objective standards. But quality is like love; its experience is unmistakable, but its measurement is well nigh impossible.

- Restraining bed supply and restricting reimbursement have cooled off

speculative investment and have contained costs. But a guaranteed baseline reimbursement has protected operators from market competition. Economic security has weakened their incentives for good care, efficiency, better management, stable staff, optimal services and innovative practices.

B. The Contribution of State Regulation

Though public policy has hobbled along, regulations have made their mark. The recent Institute of Medicine study concludes what the general public has noticed: "Nursing homes today are safer and cleaner, and the quality of care, on the average, probably is better than was the case prior to 1974."[17]

- From 1980 to 1984 Medicare terminated 159 contracts; in addition, there were 967 voluntary contract cancellations. 13 states decertified 129 facilities in 1983.[18,19]

- Although federal regulators punish poor behavior and do not reward excellence in care, a few states have installed systems to reward good and outstanding homes.

- Both Congress and HCFA have sensed the value of the geriatric nurse practitioner and are actively promoting the role. Several states have led the way in this regard.[20]

- The industry as a whole has responded positively. Some proprietary nursing home chains have installed rigorous quality assurance programs.[21]

In the larger view, then, government policy has pulled its weight. It has weeded out the worst offenders, and has nudged the industry in the right direction.

CHAPTER 4

REGULATION: THE ILLINOIS EXPERIENCE

A Summary

Illinois found itself in the same boat as the rest of the nation in regard to the deplorable conditions of its nursing homes in the early 1970s. But several events singled the state out for special attention. And the state moved with edifying speed to clean up the mess.

A. The Progress in Illinois

The reform regulations in Illinois are among the strictest in the nation. On a scale of 10, according to a fervent critic, the Illinois home industry had to rank minus 3 in 1970; in 1976 it was more likely plus 7.[22]

- The federal government was impressed by the Department of Public Health which installed an automated system to aid regulation. It requested the Department to help other states to adopt similar measures.[22]

- For five years up to 1983, the state let nursing home beds increase a bare 2.4 percent, when the nation allowed an increase of 10.2 percent. Beds for every 1,000 seniors fell 7.4 percent as against a national drop of 2.8 percent. Admissions declined, and so did days of nursing home care paid for by Medicaid.[23,24]

- While utilization fell, the Illinois reimbursement rate climbed 52 percent in the six years since 1976. The nursing component rose the highest with a

63.25 percent jump.[24]

- Critics bemoan Illinois' average $37 daily reimbursement rate. But the regulators contend that rate increase does not assure better quality, since many nursing homes already rake in hefty profits from Medicaid payments.[25]

- Illinois' minimum requirements for nursing hours per resident day are among the highest in the nation. The state requires 120 hours of training for nurse's aides, second only to California's 150 hours. In 1983 an impressive 72 percent of Illinois' facilities were not cited for A-key deficiencies--among the best records in the nation.[26]

B. Leadership in Long-Term Care

In defiance of sound management theory, federal regulations seek to improve quality through sanctions rather than with incentives. A handful of states encourage superior performance with positive rewards. You will find Illinois in the forefront of such efforts.

- Illinois initiated a Quality Incentive Program in 1981, and restructured it in 1985.

- The Department of Public Aid committeed $9 million for QUIP in 1984, increased it to $19 million in 1985 and again in 1986, and may add another $2 million to the pot for 1987.[27]

- 600 of the 700 Illinois nursing homes participate in QUIP. 134 nurses assess their performance; they also inform and educate providers through extensive education and consultation.[27]

- QUIP nurses have uncovered a $15 million administrative leakage which the state has now plugged. QUIP's six-star award has emerged as a

enviable symbol of excellence. More facilities have participated in each succeeding QUIP assessment. QUIP participants have improved their performance between the two 1985 assessments.[28]

- The QUIP concept is spreading. Other states are contemplating using the QUIP model. QUIP has just won a prestigious national award given by the Ford Foundation and Harvard University for the 25 best innovations in local and state government around the nation.[29]

The Department of Public Aid has initiated two other innovations in enhancing nursing home quality.

- First held in 1985, the Governor's Conference on Long-Term Care will take place annually as a major source of information about nursing home innovations.

- The Department has set up a Task Force on Long-Term Care Research. It has committed $1.25 million for two years in a row to draw academic institutions and providers into collaborative research and demonstrations that improve the quality of Illinois nursing home.

On balance, then, several objective measures place Illinois in the respectable company of superior achievers among states.

In summing up, this section has set the backdrop to highlight the story of the exemplary homes in Illinois. The nature of quality is elusive, and its attainment a problem in American nursing homes, because long-term care suffers from a systemic flaw.

Nursing homes carry the burden of a checkered history, an uneven public policy, little public respect, an indifferent public commitment, a meager reimbursement and inadequate regulation.

That some nursing homes can clear all these hurdles, that they can go

the extra mile and that they can rise above mediocrity are both edifying and instructive.

The superior homes did not merely stumble on to success. Adoption of a few techniques does not guarantee excellence. Excellence results, as we shall see, when artful managers creatively blend commitment, resources and programs.

SECTION II

EXEMPLARS OF QUALITY

Models of exemplary care to our frail elderly exist all around us. The intent of this study was to focus on a handul of these superior nursing homes. We were eager to find out how these homes do it, how they achieve that success, what paths they take to reach the top, what lessons they hold for the rest of us.

We have noted in the Introduction that we confined our study to Illinois. We were properly edified to discover that the number of superior homes in the state is truly impressive. Our purpose, however, was not to take a census of good homes, but to understand their strategies. So we only selected a sample of eight homes that reflect the color and variety of the superior facilities in the state. We have described in the Introduction how we went about our choice. The selection proved to be a joy, leaving out all the other outstanding candidates was the hardest part.

Who are these champions of the elderly, the models of care, around whom this study revolves? We sketch in this chapter a capsule portrait of each of these eight nursing homes. These profiles reveal a splendid diversity of character, size and location. Each one is unique, each a shining case of devotion, imagination and skill—all of which add up to a star performance on behalf of the seniors. Together they tell us eloquently that quality in nursing home care is no one's monopoly. Where there is commitment, and some ability, there is a way to attain excellence.

CHAPTER 5

PROFILES OF QUALITY NURSING HOMES

Quality is like good wine. You may not be able to define it, but you know at once upon tasting it if it has gone sour. So with good nursing homes. You will immediately recognize superior quality should you visit the eight stars around whom this study revolves. Their day-to-day life illuminates the meaning of quality more surely than any scholarly disquisition ever could.

Still, excellent homes are all unique. Exceptional nursing home care is not unlike any great human achievement: it is achieved through a creative blend of commitment, management and resources. While the mediocre look for the easy cookbook approach, talent tends to break out of the mold, it pursues imaginative paths. For, there are indeed different paths to paradise. Therefore you never find two saints alike.

Our brief, broad-stroke sketches of eight eminent homes in this chapter illustrate the special character and color that make each of them a distinctive exemplar of quality. These profiles set the stage for the central discussion of this study. Excellent homes are indeed distinctive; still they all take inspiration from the same basic principles and live by the same fundamental canons of quality. The six chapters in Section III discuss these dominant principles which superior homes embrace, the guideposts that have kept them on the sure road to excellence.

A. APOSTOLIC CHRISTIAN RESTMOR

935 East Jefferson
Morton, IL 61550

(309) 266-7141

Apostolic Christian Restmor, a 146 bed nursing home, opened its doors in 1961 as a proprietary facility and it continued as a for-profit home till 1978 when the Apostolic Christian Church of Morton acquired it. The Apostolic Christian Churches of America run 12 nursing homes around the nation with a concentration of facilities in central Illinois. They are all owned, however, by one or more of the local Churches. Although its mission is primarily to take care of Church members, Restmor opens its doors to all elderly regardless of religion or race.

Residents and Staff: Pride and Satisfaction

Restmor, like three other homes in our group of eight, is certified for a few Medicare beds; 18 in this case. During the course of our study, however, none of them had any Medicare residents. With the advent of DRGs, nursing homes had girded themselves for an influx of Medicare patients. But the hospitals got into the act, opened skilled care beds, and began to skim the cream off the long-term care market. In some regions relations between nursing homes and feeder hospitals have been strained over this issue.

You will also notice that only 15 percent of Restmor's residents receive Medicaid, a low Medicaid occupancy for a facility with only 18 percent sheltered care beds. But in this regard, Restmor remains typical of the homes in central and southern Illinois. Our seniors in rural America, as studies show, are a proud lot and sensitive to anything that smacks of a handout. They go to

extreme lengths before they are willing to accept Medicaid. And Restmor accommodates them: its private pay rate is decidedly modest.

You would have to score 70 percent on resident satisfaction before QUIP would pin a gold medal on your facility. Restmor won a stunning 91 percent! The smile on Restmor's residents aptly summarizes the character and tone of the home. Excellence, devotion and pride are written all over it.

You notice pride and commitment among the frontline troops, the nurse's aides. They are fiercely loyal. Only 10 percent of them leave the facility in any given year. The turnover rate is a negligible 4 percent among the professional staff. You ask the employees if they are satisfied, and in one voice they will respond: "Of course!" 70 percent of those whom we asked said they were "very satisfied"; none showed a trace of dissatisfaction. Almost 9 out of 10 of them told us Restmor is the best home there is, 12 percent rated it better than most!

Management: A Splendid Record

Morton's Apostolic Christian Church brought in James Metzger as Administrator in 1978 when it took over Restmor. Mr. Metzger, a devout member of the Church and a professional to his finger tips, is a pharmacist by training with a hospital background. He handpicked Ms. Judy Witzig as the Director of Nursing. Excellence could be her middle name, and she has promoted it for 7 years. Her Assistant Director of Nursing, Ms. Barbara Dudis, has served devotedly for 12 years.

How do you judge good management? At least by two tests: the quality of their product, and through the eyes of their staff. On the first count, Restmor's managers should wear the broadest smile. Their care is unexcelled. The community will tell you that, and so will the feeder hospitals, the QUIP nurses and the residents' families.

On the second test, they garner enough kudos from the staff to warm the heart of any manager. We spoke to a cross-section of them. What we heard amounts to a finest profile of professional managers. "They set high standards and goals, and help us achieve them", a nurse's aide told us. "They

are always trying to improve things for residents and employees", said another.

The staff describes the management as fair, supportive and caring. "They take time to hear what you have to say"; "I feel wanted"; "they listen to new ideas and complaints"; "they try to solve problems." That is what the staff told us, and that is what we saw.

James Metzger is a superb example of a people's manager, as we describe one in Chapter 7. He nourishes his employee's egos and constantly rewards their achievement. He has put together a unique benefit and incentive package. He values professionalism, and so he picks up the tab when staff continue their education. He knows what makes people tick, so he provides differential wage incentives for difficult shifts. He has opened a credit union for the staff and offers them a pension plan.

Unique to James Metzger is a days-off package that the staff loves him for. A Restmor employee has 4 paid weeks off a year. You may take those days off as holidays, personal days, sick days or whatever. It simplifies bookkeeping, saves the staff the problem of bringing in medical evidence, and generally makes life easier and happier for all.

The Restmor Difference

The first thing that strikes you about Restmor is its symbiotic bond with the Church. The Church has taken the facility to its bosom. The concern for Restmor dominates the deliberations of the Church elders; it shows in the Church's services, its community activities and its fund raisers. Church members generously donate their money, time and love for the well-being of Restmor's residents.

A second thing that you will surely notice at Restmor is the happy marriage of old-fashioned love and devotion with the high-tech efficiency of modern management. Mr. Metzger loves computers. The computer energy sensors at Restmor have dramatically increased fuel efficiency and reduced operating costs.

You associate computers with drab anonymity and sterile numbers. Would you have expected that Restmor would use them to enhance personalized

care? The computer holds all the resident data at Restmor, and you can recall it in an instant, any aspect of it, any time. The computer prints out reminders to nurse's aides of their daily and weekly care assignments individualized for each resident under their charge. It does that also for nurses who dispense medications. And on and on it goes, the computer as the enhancer of individuality and care at Restmor.

Innovation should be another name for Restmor. They constantly seek ways to improve care. The drug-holiday program is one example. Their Alzheimer's program is another. It won the Governor's award.

The community considers Restmor its shining star.

B. BURGESS SQUARE HEALTHCARE CENTRE

5801 South Cass Avenue
Westmont, IL 60559

(312) 971-2645

Burgess Square was opened under a different name as a proprietary facility in 1970. It has remained proprietary but has changed hands three times. In 1984 Ms. Jacqueline Mason acquired it and gave it the present name.

Burgess Square has 210 beds with 15 of them Medicare certified. About half of all beds are assigned for skilled care and the other half for intermediate care. Burgess Square offers no sheltered care.

Residents and Staff: Remarkable Progress

In order to appreciate where Burgess Square is, you have to know where it came from—far, far behind. When Jacqueline Mason took over, the care at the home was less than superb. If bed sores in a facility tell you that a sad state of affairs prevails, then Burgess Square had many a mile to go before reaching any quality worth mentioning. The community is the ultimate judge of quality. It refused to patronize Burgess Square; so, many of its beds remained empty.

In a remarkably short period, in less than a year in fact, Burgess Square turned around. It won QUIP's six-star award on the first round in mid 1985, and then again twice in a row, with the last one in the summer of 1986.

QUIP uses elaborate criteria to measure quality of care. One of these is "resident participation and choice." On this criterion, QUIP assesses a nursing homes in two ways: the level of resident participation in meaningful

activity and the quality of that participation. The evaluation process is complex and involves both the observation of residents and the analysis of their care plans. To pass the QUIP test, a home has to score a minimum of 70 percent in each case. Burgess Square pulled off 93.82 percent on the level of resident participation and choice, and an enviable 97.14 percent on the quality of that participation and choice. Similarly, resident satisfaction was found to be well above the minimum QUIP standards.

Happy residents have to mean a committed staff. Burgess Square is putting in place such a staff. Though the new owner acquired the facility, plagued as it was with a high staff turnover, Burgess Square has improved quality and has stemmed the tide. This, despite the fact that it has had to weed out the malcontents that stayed on. Nurse's aide turnover has dropped to 25 percent and that among professional staff to 20 percent.

Staff satisfaction serves as a better index of their morale. We questioned 30 caregivers at random. Only 2 among them were dissatisfied, and none "very dissatisfied." 93 percent, in contrast, were satisfied with Burgess Square, and almost half of these confided to us that they were very satisfied—a remarkable upward satisfaction curve in so short a time.

You should ask the staff how good Burgess Square is. We did. 60 percent told us that it was the best of nursing homes there is. 1 in 3 said the home rates better than most. Only 1 of the 30 we questioned said that it was the same as most homes. None rated it worse.

Management: A Committed Team

Ms. Mason took over Burgess Square in 1984. She had managed nursing homes for 20 years before that. So she knew the secret to nursing home care: quality first and quality last. Without a firm and undiluted commitment to quality, there is no point in owning and operating a nursing home.

She also knew the key to success: a committed team. She possessed that key. Over the years she had forged such a management team. She walked into Burgess Square with a team she had already put in place.

Ms. Jo Anne Fisher, the Administrator at Burgess Square, has worked

with Ms. Mason for 15 years. Ms. Nell Fields, the Assistant Administrator, has done the same for 10 years; a second Assistant Administrator, Ms. Kathy Sefcik, for 8 years; the Director of Nursing, Ms. Irene Kubina, for 9 years; and the Assistant Director of Nursing, Ms. Peggy Obert, for 3 years.

The advantage the Burgess Square team possesses is that it understands what quality is, and that it goes after it with single-mindedness. At Burgess Square, status is second, the team purpose comes first. Every one knows what is at stake, so every one gives whatever it takes. They don't stand on ceremonies, every one readily steps out of one's role, pitches in and sees that the task is done.

The rest of the employees get the management message clearly. A licensed practical nurse has noticed the difference. She has been there for 6 years and has seen owners come and go. Of the new managers she told us: "They all work together here as a team, they would not ask you to do anything they wouldn't." Quality of care? "They truly care about the residents," a nurse's aide told us, "they know them by name and personality."

The employees also see that Burgess Square management does really manage. "Everything is in good order here," a nurse's aide said. "They are well organized," added another. The management on its part genuinely values its workers. An aide revealed to us the Burgess Square approach: "I am respected here as a person. I am trusted to manage my department." "They give credit where credit is due," said another. The staff also confided to us that the management is accessible to them, even at the highest level. Managers at Burgess Square listen; they are concerned about the aides.

When Burgess Square opened, it found its aides already belonging to a union. Unionized facilities participate in multifacility negotiations with the area unions. Generally speaking, individual facilities have little leeway to provide special benefits and incentives to employees.

Yet, Burgess Square has installed a simple and effective incentive to deal with call-ins and tardiness. It provides a 10 cent per hour bonus to the ones who show up regularly and on time. With a fine sense for the effectiveness of immediate rewards, Burgess Square pays off this bonus every pay period. Unused sick days are paid as Christmas bonus. The formula has

worked with astonishing effect.

The Burgess Square Contribution

For the present study, the contribution of Burgess Square is paramount. Here was a facility, down and out and in an unenviable situation. A new owner comes in, makes no apology for her for-profit orientation, installs a new management team—enlightened and committed—and achieves a stunning success.

With no tradition to fall back upon, with no privileged status or circumstance, Burgess Square pulls itself up by its boot straps. From rags to quality. Burgess Square did it. It is indeed a triumph of a philosophy and a management style.

C. DUPAGE CONVALESCENT CENTER

400 North County Farm Road
Wheaton, IL 60187

(312) 665-6400

The DuPage Convalescent Center opened in 1888 as a poorhouse and, true to its character, provided only shelter and board, but no health care, to its residents. Times changed, and its character changed with them. By 1932 the Center was taking in people who needed care, including TB patients. The Center is run by the County of DuPage which sets its budget and policies including those that determine staff benefits.

With 408 beds, the DuPage Center is among the largest nursing homes in Illinois. It has 15 Medicare certified beds, but rarely any Medicare residents. It has nearly twice as many intermediate care beds as skilled ones, and no sheltered care beds. 78 percent of its residents are on Medicaid.

Residents and Staff: A Privileged Group

The DuPage Center enjoys an enviable reputation. An endless waiting list testifies to its superb care. QUIP nurses find that the residents at the Center are a highly contented lot. They gave the Center a 86.62 percent rating on resident satisfaction.

The QUIP performance on how residents participate in meaningful activity registered an even higher score. The level of participation and choice achieved a score of 93.82 percent and its quality a splended 97.14 percent.

You will hardly visit a facility with a more complete and successful activity program. Generously endowed and professionally run, the activities

which the residents participate in at DuPage are near endless, and the way residents participate in them is positively edifying. The DuPage Center offers an enlightened model of nursing care which stresses restorative care and blends it creatively with social aspects of daily life.

The staff at the Center are a fortunate group. No other facility in the state, we dare say, offers such a generous remuneration and benefits to employees of a nursing home with as great a Medicaid population as does the DuPage Center. The County sets the employee policies as well as the salary and benefit package, although one suspects that the soft-spoken and effective Administrator, Ron Reinecke, helps sweeten the pot considerably.

If you seek to know how satisfied the staff are at the DuPage Center, you will find that morale runs high. Among the 45 whom we questioned, we encountered only one disgruntled soul. 55 percent express satisfaction and 43 percent say they are very satisfied. On our other indicator, 3 in 4 rate the home the best there is, 1 in 5 consider it better than most. And would you not know it, we found one that rated it worse than most!

Despite a generous wage scale and benefits package, and in the face of an unexcelled management style, the DuPage Center suffers a loss of nearly a third of its nurse's aides a year. We discuss this odd phenomenon in Chapter 10. External forces, we find, take their toll. The professional nurses, however, stay on. Only 1 in 5 quit in one year.

Management: A Success Story

Mr. Ronald Reinecke has served as the Administrator of the DuPage Center for 23 years. His assistant, Ms. Ginger Leavitt, has worked at the Center for 10 years. Their Director of Nursing, Ms. Kathy Wiggins, returned to the Center after an earlier stretch of service and has completed 6 years in her present position. Her predecessor retired after serving for 10 years. The Assistant Director of Nursing, Ms. Christine Nizetic, has worked at the Center for 14 years.

Continuity, then, is what characterizes the management team at the DuPage Center. That implies a continuity of purpose, policy and care. And

what will hearten you most of all at the Center is that all this spells quality, notwithstanding the mammoth dimensions of the facility.

Mr. Reinecke's formula for success is to run many nursing homes in one. He has divided the Center into semiautonomous units each with its own identity and character. Residents and staff take pride in their own enclave and even engage in friendly rivalry with other units.

Another Reinecke success is the care planning process. An interdisciplinary team caucuses twice a week on a two hour basis, and patiently and devotedly works and reworks on resident care plans. The results are palpable even to a casual visitor.

DuPage Center has opened its doors wide to the surrounding community. Professionals, volunteers, families and churches move in and out of the home in a constant flow. They bring in entertainment, they donate services, they supplement the care, they contribute to the uniqueness and quality of the DuPage Center.

The Singular Success of the DuPage Center

The DuPage Center is a shining example of a continuous, high quality of care to our seniors. It is a government facility, but unlike many another public enterprise, it boasts a high respect from the public. The community gives of itself to the DuPage Center with unstinted generosity.

The DuPage Center has evolved from a patchy history. Its size is unwieldly, its location is inconvenient, it risks from being used as a political football. Yet the Center has risen above all its handicaps. An enlightened and able management has insulated it from public controversy, it has put together an able staff, it provides its residents the best care there is.

The DuPage Convalescent Center is a singular success. It serves as a worthy model.

D. LAKE BLUFF HEALTH CARE CENTRE

700 Jenkisson Avenue
Lake Bluff, IL 60044

(312) 295-3900

The Lake Bluff Health Care Centre has been a proprietary home since its inception in 1977. Robert Hartman acquired it in 1981 and included it in his chain of five nursing homes in the Chicago area. Two homes in this chain, including Lake Bluff, have won a QUIP six-star award. Lake Bluff is thus the second of the two for-profit homes we have included in our group.

Lake Bluff offers no sheltered care. About 4 in 5 of its beds are slated for intermediate care and the rest for skilled care, 15 of these being Medicare certified. The nursing home is located in the affluent suburban area north of Chicago. Its clients generally come from comfortable backgrounds and bring with them higher expectations about nursing home life. Lake Bluff charges a higher rate for private pay residents than most others in our sample. On any given day, one half the residents in the home are on Medicaid assistance.

Residents and Staff: The Tide Turned

Lake Bluff is a modern facility, although it has some awkward structural features that reflect the developers' stereotypes in the mid 1970s. Before the new owner took over and installed the present management, the care to the residents was probably good. The new management, however, found beds empty, employee morale in the dumps, a steady staff hemorrhage and disastrous public relations. All this in a higher priced home!

In a little over five and a half years we found that Lake Bluff has picked up the pieces and is off and running. It contested for the QUIP award and just fell short of the perfect rating and secured five stars in the first round in mid 1985. By year end, however, when QUIP nurses returned, they were impressed by the progress. Lake Bluff ran away with a perfect six-star award.

Whether it is care plans, or the level and quality of resident activities, or the level of resident satisfaction, Lake Bluff passed the QUIP test with a comfortable margin. The community too has noticed the difference. All the beds are now full and the waiting line is growing. The home has stabilized, so structural modifications are under way. New beds are about to be added.

You cannot achieve quality of care without resolving the staff problem. Given its higher socioeconomic status, the Lake Bluff community supplies few nurse's aides to nursing homes. So the facility reaches out to far flung communities to draw its aides and support staff.

Distance and transportion, therefore, make recruitment a problem. Nurse aides from outside communities tend to shop around for better deals among nursing homes and other employers. This aggravates attrition and instability. But Lake Bluff tackled the issue successfully both within the home and in the community.

The aides turnover has dropped at Lake Bluff to 10 percent, about the best we know anywhere. Hardly any nurses left the facility last year. We polled the staff, and unforturnately got only 7 in our sample. Among these we met one who said she was very dissatisfied. All the rest, i.e. 86 percent of them statistically speaking, declared themselves very satisfied.

How do the staff rate the home? Their loyalty to the facility apparently stems from the pride they feel in belonging to the home. Almost a third of them find Lake Bluff the best, the rest rate it better than most.

Management: Experience and Common Sense

Mr. Hartman, the owner, showed a sure instinct when he recruited James Bowden in 1981 to run the Lake Bluff home. Mr. Bowden, a hearty Irishman, brought to the ailing facility a fund of experience in running nursing

homes, loads of commonsense and an irrepressible humor. "He reminds me of my dad," a staff member told us with some affection.

Mr. Bowden says he was wooed into running a nursing home by a Catholic priest in Minnesota way back many moons ago. He left his advertising work, fell in love with elderly, and never turned his back on them. "You cannot be in this business without lots of TLC," he will tell you.

His TLC shows. He has put together an expert team of like-minded staff that are an extension of his caring personality. He has recently recruited Mr. Sam Gentile, an academic, as an Assistant Administrator. Ms. Pat Miller, now the Director of Nursing, has worked at Lake Bluff for many years, and got promoted from within 5 years ago. Her Assistant Director, Ms. Carmen Ware, has served at the Centre for 3-1/2 years.

Mr. Bowden and his merry team are a living example of the leadership style popularized under the label, Management By Walking Around, to which so many homes pay lip service, but which few grasp and which even fewer practice. You will find the Lake Bluff managers always with their troops, patting their back, lending a helping hand, motivating them, and communicating by word and example what nursing home quality is all about.

Mr. Bowden offers his employees excellent benefits, loans them money, listens to their troubles, cajoles them and teaches them what respect and love to the elderly are all about. He is the father figure of Lake Bluff, and obviously enjoys giving his "fatherly fire-side chats."

His workers respond to him generously and work for him enthusiastically. On three separate occasions the local unions have come to Lake Bluff to recruit the nurse's aides, and each time the aides have opted for the status quo.

The Lake Bluff Character

The Lake Bluff case provides yet another compelling proof that the road to good quality is paved with commonsense, commitment and a good sense of proportion. Lake Bluff does ordinary things extraordinarily well. Proprietary or not, whether standing on a glorious tradition or starting off on a

rocky road, all that a facility needs is a simple vision of service, a dogged determination to achieve it, and a commonsensical effort to work towards it.

You might not expect a community to rally around a proprietary nursing home. Lake Bluff will prove you wrong. Its volunteer force is a sight to behold. The community is constantly present in the Lake Bluff home—the churches, its ministers, school children, entertainers, professionals and volunteers of all stripes.

The community appreciates commitment to its seniors. When it sees that you truly work for quality, it gives of itself unstintingly. Lake Bluff provides proof positive that quality is not only its own best reward, but it can also be profitable and a great deal fun.

E. NORTHWEST HOME FOR THE AGED

6300 North California
Chicago, IL 60659

(312) 973-1900

The Northwest Home for the Aged evolved to its present form from its 1944 beginnings: a classic case of a humble community effort blossoming into a glorious institution. In that year some Jewish friends pooled money and opened a few beds for the seniors in different apartment buildings. It moved to its present location in 1972.

The Northwest Home has 160 beds, none of these are for sheltered care, 59 percent are designated for skilled care and 41 percent for intermediate care. Nearly two thirds of all its residents receive public aid.

We included in our sample this example of superior care to the elderly, because of its cultural uniqueness. Though Northwest opens its doors to elderly of all religions and races, you will rarely find a non-Jewish resident in the facility. A pronounced Jewish culture pervades the home. Northwest builds its care on this cultural consensus. It uses this solidarity creatively to provide a sense of belongingness, an identity and a continuity that make Northwest second to none in its commitment and service to the seniors.

Residents and Staff: Autonomy and Pride

If you scan the QUIP records you quickly notice that the Northwest residents are indeed a happy lot. That is no surprise; they receive excellent care. You will also notice that the nursing home's percentage scores on the level and quality of resident choice soar into the nineties. You have to visit the

home, however, in order to realize the full import of that achievement.

At Northwest the oldest of its residents have a significant involvement and influence on the character and operation of the home. The facility draws on their expertise and commitment. These seniors are proud of their home and carry its message to the community. Once they have decided on a project, the issue of money will rarely arise. They will get the community involved, draw on their network of contacts and see the project through.

A group of six elders runs the synagogue which is located centrally in the home. They make all the decisions about hiring a rabbi, about the services, about the festivities, about its budget and about its operation. They get the other residents involved in the vibrant life of the synagogue. They keep the management informed, but hardly draw it into their deliberations.

Northwest staffs its floors generously with nurses and aides. Its work force is unionized. The multi-facility contracts with the unions generally put severe limits on what individual homes can offer their aides by way of incentives, bonuses and benefits. Yet Northwest has welded together a cohesive, loyal group of workers who travel long distances to come and work there.

In the last year Northwest lost only 10 percent of its aides, and none of its nurses! A remarkable achievement indeed. Of the 30 workers we interviewed only one expressed dissatisfaction with the home. 96 percent of them, we found, are well satisfied; a third, very satisfied. With considerable pride and emotion they will tell you what they think of their home. Over 3 in every 4 workers hold Northwest to be the best of all those they have worked in or know about. The rest rate it better than most homes.

Management: Innovative and Caring

The Board of Trustees of the Northwest Home has involved itself heavily in its well-being. They are sensitive to the issues of quality of life at Northwest; they serve as its ambassadors.

After considerable thought they chose Haim Perlstein as the Administrator at Northwest six years ago. Mr. Perlstein, originally a school

teacher in Israel, worked in the proprietary nursing home sector in the U.S. Northwest has changed under his leadership: it has been remodelled, 10 beds have recently been added, programs have increased and staff has been upgraded.

Mr. Perlstein functions without an Assistant Administrator. His Director of Nursing, Ms. Evelyn Liberson, has worked for 13 years at Northwest, and her Assistant, Ms. Mary Pavkovich, for 12 years.

Northwest's management strikes you as efficient, innovative and caring. Mr. Perlstein sets the tone. You never see him in a rush, he speaks of big ideas and a grand vision, he takes time to respond to the tiniest request from a resident. Above all, quality of care is what he is after. You pursue quality and the money will follow, that's the Perlstein approach. It works!

The staff has gotten the message. "The management is very friendly and warm, truly concerned about the residents," said a nurse. "It is team work here, and high goals," another one told us. The best thing about management that impresses a third nurse is "their high standards and cooperation." "It is decentralization," according to still another. They are considerate, they are fair, they listen, they help. That is how the staff describes Mr. Perlstein and the rest of his management team. So, they exude pride, loyalty and commitment.

Northwest's Priority

You sense Northwest's priorities if you consider its recent projects. Cramped as the facility is within a part of a city block, Northwest has installed a splendid library. Its synagogue takes the pride of place in a central location. The latest expansion project includes a beautifully designed all-weather sun porch where any resident can wander or be wheeled in.

Northwest has, with great effect, demedicalized its care model by blending it with the social, intellectual and spiritual life of its residents. Its restorative approach is symbolized by its emphasis on physical therapy. Northwest stresses socializing, and provides ample space, a gracious setting and appropriate programs to achieve that end.

What you see at Northwest is an effective use of the facility's cultural identity, its high standing in the community, and a superb and caring management. All these resources are marshalled imaginatively towards one goal that Northwest holds close to its heart: restore the resident's life to its full physical, spiritual and emotional potential. Northwest achieves that goal brilliantly.

F. NORWOOD PARK HOME

6016 North Nina Avenue
Chicago, IL 60631

(312) 631-4856

The Norwood Park Home was started as the Norwegian Old People's Home in 1896. It grew out of a concern for the elderly with modest means on the part of the Norwegian Old People's Home Society, and especially its first President, Niles T. Quales, a Norwegian-born physician.

The Society, founded on the principles of the Lutheran Church, acquired the Norwood Park Hotel, and, with 17 initial residents, officially opened the Home on August 8, 1896. The waiting list of applicants grew so fast, that the Society erected a new building in 1909. On a cold night ten days before its scheduled formal opening on January 5, 1910, the building fell victim to a roaring fire. The indefatigable Society erected the present structure in its place and opened it on November 26, 1910.

Norwood Park sustains your faith in human creativity. Here's a facility with an aging physical plant, a fading Norwegian identity, and located within a community which is a far cry from the original pioneers that gave birth to and then sustained Norwood Park. Yet an old-fashioned family spirit prevails in the home. It is vibrant, it is uninhibited, and it is infectious. Both the residents and the staff will tell you that Norwood Park is, in the true sense, a home. And they love it.

Norwood Park offers no skilled care. Its beds are about equally divided for intermediate and sheltered care. Therefore, as is common in facilities that predominantly provide sheltered care, only about a quarter of Norwood Park's residents receive Medicaid subsidy.

Residents and Staff: Solidarity and Affection

Respect for the individual is one of the hallmarks of Norwood Park. You see it not only in the courtesy and kindness when the staff relate to the residents, you see it also in Norwood's institutional style. The management's priorities, the floor meetings, the dining room setting, all these and more exude respect and celebrate the dignity, choice and potential of the residents in the home.

The QUIP records reflect Norwood's commitment to resident self-sufficiency. The QUIP nurses found the home to be so good in this regard, that Norwood Park tops the 96 percent mark on both level and quality. Resident satisfaction, both by QUIP account and by our own observation, runs very high.

Good care means quality staff. And quality is a label that well describes the devoted staff Norwood Park employs. In cohesiveness, comraderie and sheer dedication they should be the envy of the nursing home industry. Last year only 1 in 5 aides left the facility, as did 1 in 10 of the nurses—a proud record typical of good homes. A remarkable 95 percent of the staff told us that they were satisfied or very satisfied with Norwood Park. About three quarters of them think Norwood Park is the best of all homes, and a fifth think it is better than most.

Numbers, however, do not well illustrate the bond the staff have established with the residents, nor their attachment to the home. The management staff and residents burst out into a spontaneous and festive celebration when QUIP rewarded their singular achievement with six stars. The staff visit the residents when on vacation and often take them out for dinners and parties. In a fine show of solidarity and affection, the staff recently donated money to have a magnificent courtyard built, which the residents now use in fair weather.

Management: Cheering Them On

James Herbon is Norwood Park's Administrator, philosopher, grand daddy and cheerleader all rolled into one. In him you have a man whole-

heartedly in love with the elders and with Norwood Park. He displays his enthusiasm openly and shows his emotion unabashedly. They will rub off on you if you stick around. He has served Norwood Park for 20 years. His Director of Nursing, Mrs. Nancy Lucarini, has been at the home for 12 years. Her Assistant, Ms. Marianne Nelson, has worked there for 6 years.

Mr. Herbon has a clear concept of what elder care should be, and his message rings out unmistakably and its tone pervades the facility. He will vehemently contend that Norwood Park is a home for the elderly, and not a nursing care facility. The home is where your heart is, where your dignity remains in tact, your individuality respected and your security assured; it is a place where you belong.

Take Norwood Park's food service, for instance. It easily ranks among the best. Not only its quality, but even the flair with which food is prepared and served stand as a supreme example of how a facility can deinstitutionalize food, and how meals can become a celebration. Norwood Park's outstanding chef will unexpectedly create elegant arrangements with fruits and food dishes. A fanciful ice carving may suddenly grace the table. In many subtle ways Norwood Park tells its residents that they are special enough to be fussed over.

Mr. Herbon comfortably fills the role of a crusader and a cheerleader. He constantly imparts his message to his staff, to the community, and to his Board of Trustees, some of whom are now Norwood Park's most active volunteers. As a manager he would rather cheer his staff on than scowl at them when they trip. He offers them excellent benefits and incentives, and draws them into decision making.

And the staff respond warmly to the management. "We tell it like it is," said one worker; and "they listen to us," added another. The management sets clear principles, but within those limits they encourage discretion and innovation.

Norwood Park's Approach

Norwood Park views itself as a family. So the confused residents are

not segregated from the rest. The staff dine with the residents. "We live like a family," says James Herbon, "we laugh like a family and quarrel like any other family does. But watch out. If you challenge us, we'll fight you to the end."

All this amounts less to a medical model than to a wellness and social model. Norwood Park is a home, and so its life follows the rhythm of a home life. It places its accent squarely on wellness and individuality.

G. SAINT JOSEPH'S HOME FOR THE ELDERLY

8 West Northwest Highway
Palatine, IL 60067

(312) 358-5700

St. Joseph's Home for the Elderly built in 1966 is the older of the two such facilities in the Chicago area run by the Little Sisters of the Poor. The Little Sisters are an international religious Congregation of Catholic nuns founded in France by Blessed Jeanne Jugan in the year 1879. Their sole mission is to serve the indigent elderly regardless of religion or race. They care for them in nursing homes on every continent, including the troubled regions of the middle east. The Little Sisters run 34 nursing homes in the U.S.

The 137 bedded St. Joseph's Home vividly embodies the ideal of the nuns to serve the indigent elderly. As a rule, a negligible number of sheltered care residents in any home are supported by public aid. At St. Joseph's nearly 40 percent of the residents receive sheltered care, yet almost two thirds of all the residents receive public aid. Excellence draws attention to itself. So the Sisters get swamped with applications. But they will only admit residents who pass an indigency test.

The St. Joseph's story almost resembles a fairy tale. Rarely would you find a better example of a simple faith, an utter devotion and a quiet enthusiasm that combine together to produce the unexcelled results you will encounter at St. Joseph's. The 15 nuns there consider the 137 residents their family. They live with them, care for them and will even refuse to leave them to go on a vacation. The nuns have made a home for them, because they believe old age should be spent in dignity, respect and security.

Residents and Staff: A Joyous Lot

If you drop in at St. Joseph's, you should visit with the residents. You will be struck, as we were, with the radiance on their faces. They will tell you both in words and in many silent ways that they are at peace in the company of the nuns. The Little Sisters have created for them an ambiance of dignity.

The ambiance of St. Joseph's is a remarkable blend of Catholic culture, humane values and high professionalism. The Sisters' motivation and their commitment to the seniors stem from their religious faith. Therefore religion and spiritual concern dominate the home. The Sisters use them with splendid effect to provide a sense of continuity with the past lives of the residents, and a sense of purpose, meaning, comfort and security in their present setting. At St. Joseph's, religion serves as a spiritual anchor, it makes for a common bond, it humanizes death.

A sense of joy permeates the home. No wonder the QUIP nurses scored resident satisfaction at 96.25 percent, the highest we have ever seen. They also picked up sufficient clues on how much St. Joseph's values the individual, and awarded the home a score just shy of the perfect 100 percent for the level of residents' choice and participation in activity; the quality of that choice and participation earned a 92 percent.

You should also visit with staff, and you will hear them harp on the same theme. Nowhere else have we heard the staff so consistently describe the management as filled with "love," "compassion," "dedication" and "kindness." A nurse said it simply: "This is the Sisters' home, and the place reflects that." Another nurse spoke approvingly of the example of the Sisters' life: "Their lives are dedicated to the elderly. So they expect us too to give a high quality of care." And obviously they do.

The same gracious attitude the Sisters show towards the residents, they extend also towards their employees. "It is like a family here. People care," said one nurse. The staff say that the Sisters are considerate and understanding: "they are good listeners." A 100 percent of the staff we spoke to said they were satisfied with their work at St. Joseph's; two thirds of these, we found, were very satisfied. Over 90 percent of them rate the home the very

best there is, the rest say it is better than most. St. Joseph's lost a third of their aides last year, a high loss for a good home. We have addressed this issue of external constraints in Chapter 10.

Management: The Triumph of a System

We included only one of the Little Sisters' nursing homes in our sample. But a little investigation revealed that St. Joseph's is not at all unlike any other home the Sisters operate, here in the U. S. or anywhere else in the world. The source of the Sisters' inspiration is the same all over—a simple religious faith. Their dedication to the indigent elderly the world over is also the same—uncompromising and joyous.

So here you have a triumph of a system, and not merely of some enlightened managers. It is a religious organization whose goal is quality. So you find excellence of the highest order in every nursing home the Little Sisters run. The nuns circulate among these homes, and continuously revitalize the operations, the staff and themselves. So they always give unexcelled care to the elderly whereever they serve them.

In the U. S. the religious Order circulates their Sisters among their nursing homes, usually on a three year schedule. Mother Gertrude Mary, a New Yorker, has served as the Administrator for one year at St. Joseph's. Sister Mary Thomas has been the Assistant Administrator for 6 years. The Director of Nursing is Sister Catherine, another New Yorker, has been at St. Joseph's for 2 years. Their Assistant Director of Nursing has been at St. Joseph's for 15 years. She is Ms. Mary Druger, not a religious sister.

One may wish to meticulously dissect the management style of the Sisters and of their organization. The exercise would prove enormously fruitful. But for our purpose, we will only note one of its striking features. Simplicity and clarity of goals are what impress you right from the start about St. Joseph's. The Sisters are driven by a clear vision; they articulate their principles simply and clearly. They set an uncomplicated goal for themselves and their staff. Their direction is always clear and they pursue it single-mindedly.

Not long ago the Sisters decided that the best way they would serve

the community would be by converting some beds to sheltered care. Once the decision was made, they stormed heaven and earth, they left no stone unturned till they had their way.

The staff and the community take inspiration from the way the Little Sisters go at it. So every one pitches in with time, money, services, supplies and everything else that the home needs to add to the comfort and care of the residents. Incredibily, St. Joseph's raises 60 percent of its operating budget every year.

St. Joseph's Home: Unique and Peerless

Heroes and saints may provoke you, but they are never a dull lot. It is drab mediocrity that bores you. Excellence resembles saintliness, because excellence is unique, it is matchless, it is inimitable.

St. Joseph's is inimitable because it has a personality of its own. It runs on its own singular chemistry. It is a rich mixture of high ethical principles, religious dedication, a Catholic culture and a peerless Order of nuns who blend it all together and make it work for the indigent elderly.

Excellence always inspires. So does St. Joseph's. Its character may be incomparable, but its message is universal. Our frail seniors are special people. They deserve a dignified old age. And all it takes to care for them decently is a simple, honest commitment. Marshall all the forces at hand with some imagination and commonsense, and go at it single-mindedly. As St. Joseph's has amply shown, the staff and community will appreciate your devotion. They will back you up and give of themselves generously.

H. SUNSET HOME OF THE UNITED METHODIST CHURCH

418 Washington
Quincy, IL 62301

(217) 223-2636

The Sunset Home of the United Methodist Church began in a two story home and grew out of a donation made to the Central Illinois Conference of the United Methodist Church in 1889. The United Methodists do not express any special commitment to serve the elderly. Still, they run 150 facilities for the elderly in the U. S. Their doors are open to all, and they recruit administrators on merit, not on religion.

The Sunset Home is a large 248 bed facility that offers no skilled care. It allocates its beds about evenly between intermediate and sheltered care. Hence only a quarter of all its residents receive Medicaid assistance. The lower Medicaid census is also due, as noted earlier, to the fact that the elderly in the downstate, nonmetropolitan area in Illinois do not readily apply for Medicaid support. Families make an extraordinary effort to keep an older relative in a nursing home on a private pay basis.

Although the Sunset Home does not offer skilled care, it staffs its floors generously enough to qualify for it, although it receives no skilled care reimbursement. Residents who need very heavy care are transferred to other nursing homes.

The Sunset Home does not enjoy a comfortable financial cushion. It draws in a fair share of endowments and gifts from the estates willed to the home by Church members. But they barely suffice to subsidize the generous staffing patterns and the relatively low rate charged to non-Medicaid residents. Quincy has more nursing homes than one would expect, and the

community may even be over-bedded. All this adds to the financial strain at the Sunset Home which cannot provide plush enough facilities to attract the more affluent elderly.

Residents and Staff: Patent Commitment

Despite the constraints of limited resources, the Sunset Home offers the residents what only an excellent facility is willing to offer: devoted and exceptional care. At Sunset Home they love to engage the residents in a variety of activities, because they are committed to the restorative model of care. Their effort impressed the QUIP nurses to the point that it earned the facility an enviable score of 96.75 percent on the level of resident participation and choice, and a glorious 100 percent on the quality thereof.

The Sunset Home only asked to participate on some parts of the QUIP survey in the first round. Since QUIP also functions as an educational program, the Sunset Home drew heavily on the expertise of its nurses to fill in the gaps. At the Home the commitment was so patent that the staff's learning curve soon pointed straight to the heavens. The difference was palpable. The residents testified to it. Their satisfaction level was chalked up at 95 percent by the QUIP nurses in the second round when the Sunset Home won six stars.

Sunset's calendar of events is impressive. You may notice what an importance pet therapy assumes on that calendar. We were also impressed by another detail. We ran into youngsters from the Cheerful Home day care center who were visiting with the seniors in the home. The integenerational encounter was heart warming. You could see the glow on the face of the oldsters, and the merriment at the other end of the age spectrum, as they collected candy and swapped stories and trinkets.

The Sunset Home does a fine job with their staff. In the anonymous survey we attempted to conduct, we were disappointed to receive only 8 responses. On one score these employees rate Sunset Home highly. Half of them consider the facility to be the best there is, and the other half rates it better than most. How happy are they working at the Sunset Home? 2 of the 8 said they were dissatisfied. The rest were either satisfied or very satisfied.

Last year about half of the nurse's aides left the Sunset Home as did also 2 out of 3 of the nurses. In the case of the nurses, last year was obviously an atypical year. The deteriorating economy of the area, we speculate, had a hand in the problem. The exodus of the nurse's aides is unlike we have seen in any good home. We have discussed some of its related factors in Chapter 10.

In the following chapters we contend that attrition among nurse's aides does not necessarily imply that care suffers, nor that the management may have faltered. In fact attrition may suggest that malcontents have been eased out, or that an enlightened manager has encouraged career mobility among the aides.

Management: The Caring Touch

The pace and style at the Sunset Home reflects the personality of Rev. Crede, the Administrator. A calm and thoughtful man, Rev. Crede is genuinely concerned about the residents and the employees at the home. His gentle demeanor, quiet manner and religious bent admirably suit the expectations of the residents. His words and actions bespeak his concern. The reverential response of the residents convey how much they appreciate it.

Rev. Herbert Crede, a United Methodist clergyman, has been associated with the Sunset Home for more than the three and a half years he has been the Administrator. For a brief period he served on the Board of Trustees of the Sunset Home. His Assistant Administrator, Mr. Lee Creech, has served at the facility for 4 years. Both the Directors of Nursing and Activity left the sunset Home and the Quincy area this year due to family circumstances. They had served the Home for a number of years. The new Director of Nursing, Ms. Jane Hutton, came on board 3 months ago. Her Assistant, Ms. Martha Kessler, has stayed on for 3 years.

True to his personality, Rev. Crede's management is quietly firm and progressive rather than spectacular and trendy. He would rather promote the special touches that give Sunset Home its specific character. When you visit, do not forget to drop in at the ice cream parlor. It is an attractive little cafe with charming tables and modest prices. Fresh popcorn is always available. Ice

cream is offered on the floors several times a week for those who cannot make it to the cafe. It adds a nice one-on-one touch during activity time for some passive residents.

You should not miss the River Room. It is a serene place overlooking the formal garden and with a magnificent view of the majestic Mississippi. The gardener, we discovered, was a resident who proudly tends the garden and supervises the work there.

The Sunset Glow

The Sunset Home holds out yet another example of a religious tradition, which in a different setting and a different style achieves that same coveted goal—superior quality of care to our institutionalized elderly.

The Home is set in a very average neighborhood. It endures severe competition from other well established nursng homes. The local economy has shaken the staff and robbed the home of some of its volunteer force. Yet, the Sunset Home rises above these handicaps, and provides unmatched care to its residents.

In Adams County no other nursing home has won a six-star award. The Sunset Home has achieved it twice in a row.

SECTION III

THE PATHS TO EXCELLENCE

In an industry noted for mediocrity, excellent nursing homes may be rare, but they have never been wanting. First-rate nursing homes have existed even in the most sordid phases of the industry's history. These exceptional homes reveal an important truth: high quality care in nursing homes is not beyond reach.

In this study we focused on the superior achievers in Illinois. We wanted to understand how these homes attain high quality in delivering care to our elderly. Our findings came as a pleasant surprise. Good homes give excellent care, not because they possess a secret formula, and not because they follow the hidden and mysterious road. Successful nursing homes do ordinary things brilliantly.

Excellent homes are exceptional on commonsense, they are remarkable on the basics. They love the elderly and are committed to their care, and they work hard at it. Few of their managers may be MBA graduates, but they are enthused and they have put together a devoted team. They insist on top quality and set clear priorities, but they give the staff the latitude to innovate, to experiment, and to err. They are consistent but flexible, they listen, and they learn from mistakes. They keep abreast of the innovations in long-term care, and marshal their resources wisely towards their goal.

As we noted earlier, for our purpose we focused on eight case studies that represent the wide spectrum of homes in Illinois. We could have included others in the sample. For the specific purpose at hand, it was convenient and sufficient to rely on our selection. We also studied some underachievers who provide a good contrast and comparison, but they do not hold the center stage in our discussion.

Each of the eight cases is unique in its setting and character (cf.

Appendix A.I). They even differ greatly in their operation. But they are similar on some basic features that make them remarkable. We will look at six of these attributes that eminent nursing homes have in common.

1. Excellent nursing homes develop a moral and cultural ambiance conducive to superior quality.
2. A superior management style is a distinguishing mark of all first-rate homes.
3. The better a nursing care facility, the more it resembles a home.
4. Good nursing homes open themselves to the surrounding community.
5. The better nursing homes turn their employees into caring givers of care.
6. In the best homes resident care is both superior and innovative.

CHAPTER 6

A PHILOSOPHY AND AN AMBIANCE CONDUCIVE TO QUALITY

Of all the features that make up an outstanding home, there is one attribute that overrides and integrates the others. It is the moral and cultural environment that permeates the facility and gives it the special edge that all quality homes possess.

You may find it hard to describe it, but impossible not to feel it when you are in a caring environment. How do you describe the difference between the efficient service and comfort of a Holiday Inn and the warmth, intimacy and hospitality that envelopes you in the home of the old friend with whom you visit? The difference is not in the prompt room service and the plush decor. Physical accountrements do express the soul, but do not make up for it when it is lacking.

What all good homes possess is a caring ambiance. You sense it in the faces of the residents who appear secure and relaxed; in the way the aides respond to them; in the rich interaction between volunteers, residents and staff; in the kindness of the nurses who have the time and the eye for the fine detail; in the commitment of the management, obviously enthused about their job and proud of their "family."

A. The Overarching Moral Millieu

An ambiance conducive to good care has both a physical and moral dimension. Too many nursing homes pay attention to the physical milieu, even when they lack the moral commitment that ultimately makes the difference. Bricks and mortar do not a home make. Yet too many operators have an eye on the market and reimbursement when they install expensive carpeting, maintain shiny floors and invest in fancy furnishings; but they will scrimp on adequate staff, programs, food and supplies. Beautiful facilities are often not the better

homes, for the simple reason that elegant decor, plastic smiles and ersatz concern are not what make a good home.

For the better homes which we studied, the physical environment is important, but the commitment to serve is paramount. In fact one home in our sample is an aging facility, in another some wings have not been renovated in twenty-five years, and a third suffers from a poor layout. But in each case the staff has turned it into a secure and warm home for its residents. We were reminded of the excellent nursing home American operators visited in Sweden. It might have violated the American safety codes, but it enjoyed the love, care and atmosphere of a true home.[7]

We were also reminded of the nursing care hospital in Scotland which Kayser-Jones describes. The Scottish facility is very old, but warm and cozy. It has the appearance and ambiance one finds in a Scottish home rather than in a hospital for the elderly. "The maids hurried about the hallways, humming softly as they went about their work . . . . There was a sense of order, organization and purpose to their work; there was also a strong sense of everyone working together. According to one of the kitchen staff, 'We are one big family here, and we all work together; everyone is friendly to one another.'"[30]

Four of the eight homes in our study were in sad shape a few years ago; not because they were physically deficient, not even because their care was poor. Still, there was a crucial element missing—a moral investment that can transform a good home into a great one. Then these facilities changed hands, a new management came in, and with it a commitment to the care of the elderly that makes all the difference.

A moral commitment, the old-fashioned kind, with its devoted service, affection and kindness to the residents, is the spirit that dominates these homes now, as it does all first-rate nursing homes. You see it in the exuberance, sometimes quiet, at other times irrepressible, which the administrator, the directors of nursing and activity and others manifest. They enjoy the elderly whom they serve, they take pride in their work.

James Hebron, the seasoned administrator at Norwood Park Home, is an example. "I may sound boyish, like an eighth grader; but I call it love" he

says. "There's a mystique around here, and we are all caught up in it. We are not the largest, the richest, the fanciest, but there aren't many better than us!" His Director of Nursing, the kindly and efficient Mrs. Lucarini, echoes his sentiment. "Not long ago I was serving on a regional panel working on the IoC documents. I was describing to the others our programs here. I was taken aback when they asked me, 'Why do you work so hard?' I guess I didn't realize how committed I was and how much I enjoy my work."

Loyalty, devotion and commitment are words that may sound hollow and even be considered passe. But in fact they are well and living in America's best-run companies, as the national bestseller, In Search of Excellence: Lessons from America's Best-Run Companies, amply documents. Japanese manufacturers have brought these virtues to the American factory, where they have boosted productivity and sales, and lowered product defects and personnel turnover. The authors argue that this is proof that there is no eastern magic in the Japanese productivity record. Loyalty, commitment, pride in the company's success and warm human relationships are not Japanese monopolies, but are simply basic human needs and resources.[31]

If these natural resources can be brought to fruit in the manufacturing industry, so much more can they be made to work in the service sector. The best-run nursing homes teach us how.

Take St. Joseph's Home for the Elderly in Palatine, Illinois, an example par excellence of total dedication, love and commitment. It is one of two homes in the Chicago area, and one of 34 in the U.S., run by the Little Sisters of the Poor. The Sisters are part of a Catholic Congregation founded in 1879 by Jeanne Jugan, a French nun now beatified by the Church for her heroic dedication to the indigent elderly. At St. Joseph's, a large number of the residents are on Medicaid. Even the private pay residents have to pass an indigency test and are charged only as much as the reimbursement a Medicaid resident receives.

The Sisters' devotion to their residents is positively inspirational. The fifteen nuns work in the home seven days a week. When asked about vacation, Mother Gertrude Mary, the Administrator, looked surprised. "No," she said, "you don't take a vacation from your family. This is our family and

this is our home. We take off one day a month, and eight days once a year, for prayer and contemplation. We come back regenerated."

The commitment of the nuns is contagious, even though keeping up with their philosophy and pace can be demanding, even exhausting. There has been hardly any turnover in years among St. Joseph's professional staff and little to speak of among the nonprofessionals. It is indeed a grand commentary on the out-of-fashion virtues of humility, self-abnegation and altruistic love, that during the great post-Vatican II exodus from the convent, the Congregation of the Little Sisters of the Poor lost remarkably few nuns. And even amidst the widespread drought in vocations that has followed, the Little Sisters keep on recruiting young women, often from their employees who are inspired by their self-effacing dedication.

The world may be out of practice in matters of saintliness, but it still appreciates and hankers after selfless service. St. Joseph's receives six or seven applications a day. "Our waiting line is from here to eternity," says Sister Catherine, the Director of Nursing. Their Congregation runs homes for the indigent elderly on five continents. They are among the few Westerners allowed freedom of movement in the troubled Middle East, from Istanbul to Ankara where they selflessly serve the Moslem elderly.

B. Clear and Consistent Principles

Just as love seeks out a specific object, so commitment needs a clear direction. At the heart of good nursing home care is a simple, uncomplicated philosophy: caring for the physical, social and spiritual needs of the resident with respect and dignity. While every nursing home will at least pay lip service to that goal, only the truly great ones elevate it to an overriding principle that shapes and colors their daily routine.

Good managers keep it simple. They reduce the complex world of the nursing home to a few bare principles, and sometimes capture them in a few code words or slogans. Good managers are clear and consistent on their first principles, and are fanatically attached to them. They tirelessly repeat them, and in ever so many practical ways make them a part of the nursing

home culture that staff and residents alike share.

Haim Perlstein of the Northwest Home harps on the theme that Northwest is, first and last, a home. He and his staff know all the families personally. He holds open visiting hours and insists on frequent and informal interaction. He will not let the staff be paged on the PA system as a hospital does. He will not install a sign outside that might make the home appear like an institution. He will keep reminding you that the residents at Northwest are not patients and should be addressed so.

At Norwood Park the slogan is "We are a TEAM!" "Together Everyone Accomplishes More" declares a banner that hangs in the conference room and pretty well symbolizes the team approach to care at the facility. The team includes the residents who produced many of the innovative ideas that the home has implemented. The Administrator, the staff and the residents burst into a spontaneous celebration when Norwood Park received a six-star QUIP rating. Buttons and balloons proclaiming their stardom soon festooned the home. Even a special six-star flag ran up the mast to proclaim to all and sundry that "there ain't many better than us," and that they did it together.

The Sisters at St. Joseph's Home crystallize their philosophy—shared by all good homes—in the watchwords "respect and dignity." You marvel at the way the Sisters translate the principle into the daily care of the residents. They abjure reliance on technological care because it can dehumanize you, they will seldom use catheters and mechanical or chemical restraints because they offend the dignity and self-esteem of the resident. Theirs is a no-nonsense, commonsensical approach, a robust, almost stern, love, that does not gush or ooze sentimentality. They will spend the night by the bedside holding the hand of the dying resident and recite the rosary, and the next morning bargain hard the IoC surveyors to add a few pennies to the per diem rate.

Every first-rate home takes pride in its identify. It organizes its life around a set of values, principles and symbols, all blended uniquely into a culture that the residents and staff share. That culture may be religiously inspired, as is the case with St. Joseph's Home rich in its Catholic symbolism; or as is the case with the Sunset Home in Quincy, Illinois, a United Methodist institution spare in its religious decor; or as is the case with Restmor, the

Christian Apostolic home in Morton, Illinois, where the administrator's shelf carries a title, Management: A Biblical Approach (by Myron Rush), which obviously has influenced his style. At the Northwest Home, with its all-Jewish residents, a distinct Jewish culture prevails, whereas the Norwegian tradition still persists at Norwood Park. In the other homes in our study a combination of the administrator's personality and a prevailing tradition provide a coherent framework for action.

C. A Framework for Quality

A cohesive cultural framework is not just an added frill that superior nursing homes develop. It is their frame of reference embodying their goals, their philosophy of care and their commitment to the elderly. It sets the context within which a nursing home designs its programs and defines its purpose.

In marked contrast to underachievers, superior nursing homes, as we shall elaborate in the following chapter, are, at the same time, both consistent and flexible in their style of management. Good managers are uncompromising on their basic beliefs. They clearly articulate them and single-mindedly promote them. They surround themselves with a staff that accepts their principles and furthers their cause.

With clear priorities set, and a like-minded team in place, a good manager has won half the battle. He can therefore afford to encourage the employees to be flexible, to overstep their assigned tasks, to experiment, and to try new things, because the goal is clearly marked and the boundaries well defined. But the price of innovation is error, whch a good manager understands, accepts and even encourages. However, the otherwise kind and understanding manager becomes intolerant, and even ruthless, when the essential principles are violated, not only in action but even in the attitude.

At Burgess Square, Miss Jackie Mason took over a facility with a marginal reputation in the community, with 15 percent empty beds and a grave problem with bed sores. Within a year she turned it around, made it among the three most desirable homes in the area, filled all the beds, and, with 72 percent

Medicaid residents, achieved an impressive six-star QUIP status.

Her recipe for success was simple enough. After 15 years in nursing home administration Ms. Mason well understands the barriers to good nursing home care. She has developed a coherent philosophy and clear priorities about the task ahead. Most crucially, she walked in with a management team that she had put together over ten years. They subscribe to her philosophy and share her values. Together they invested their resources wisely, starting with the basics; they improved the level of care and stabilized the unionized staff. Now Burgess Square has a waiting list.

A nursing home needs a structure of symbols, a cultural ambiance, if only because both staff and residents have a need to belong. It is a basic need humans have, to identify with, and to be attached to, a group, a cause, or an ideology. As the renowned Durkeim showed in his classic study, when the social bond unravels, suicides increase in the community.

Good nursing homes are goal-driven. Their values shape their action. Their atmosphere is conducive to good care, because it motivates the employees. It gives meaning to, and makes bearable, the daily drudgery of "bed-and-body work" that Gubrium so aptly describes.[32] You can notice the difference when you visit an inferior home. We have run into many a second-rate manager in a second-rate facility who has tried every technique in the book, and has failed, because he lacks direction and he is inconsistent. He has no vision to set the priorities right, and little imagination to nurture a caring atmosphere that spells the difference between a good home and a bad one.

Motivation, pride and strong identification were palpable in the best homes we visited. When some of them earned only a five-star QUIP award in the first round—documentation and not care was generally at issue—the management and employees were distressed. The Board of Trustees took offense and wanted to know what went wrong. And in each case the group rallied and drew a perfect score on the second round of QUIP.

"If there is a choice between our philosophy of care and fiscal prudence, we always err on the side of philosophy. That is our raison d'etre." Those are the words of Mother Gertrude Mary at the St. Joseph's Home, and

they summarize the central message of our discussion. While mediocre nursing homes litter the landscape, only those homes rise above the crowd and achieve high quality, which possess a sure moral purpose, a dominant motif of service, compassion and dedication.

All outstanding homes are distinctive in character, setting and operation. Yet, they all share one essential mark of greatness. Each one of them has developed an overarching moral framework, an ambiance that symbolizes its philosophy, sets its tone and defines its approach to long-term care.

We close this discussion with four vignettes, culled again from the life at St. Joseph's Home, for they illustrate how the culture of service and dedication permeates a home.

- Mr. Henneman, 87, was ticked off at the company that supplied the hearing aid and had collected from Medicaid. The device never worked, and the company remained unresponsive. So he got on the hot line and called Springfield to complain. On second thought, he regretted his action thinking he had put the Sisters in trouble. He was soon in Mother Gertrude's room apologising profusely. The good Mother finally calmed him down after she reassured him he had done the right thing.

- Mr. Tomchaney, 90, now on a wheel chair and very dependent, has had a full life with little place in it for God, the Church and the Ten Commandments. He was positively unnerved by the attention and kindness the Sisters showed him. He held the hand of Sister Brendan one day, and sought clarification: "Sister, why are all of you so good to me, when I am such a wretched man?" "Because God still loves you," Sister replied.

- The quiet dedication of the Sisters has its reward. Unsolicited gifts and donations stream in from persons who want to share in their work. Invariably the mail brings in occasional gifts of one

or two dollar bills with an anonymous note: "For the missions." "Do you know who these secret fans are?" Sister Catherine asked us. "They are our residents pitching in from their meager monthly allowance!"

- A little placard hangs on the janitor's closet door bearing a message from St. Paul. "DO ALL THINGS WITH LOVE." Col. 3:23.

CHAPTER 7

A SUPERIOR MANAGEMENT STYLE: THE CONSULTATIVE MODEL

A nursing home manager is unlike any other in the health care field, and especially different from a hospital administrator. A hospital is pyramidal in structure, with clear layers of authority and expertise. It follows a formal, rational model that suits its needs for technical efficiency and a sharp division of tasks. Its acute care patients expect to be dependent, they readily yield to professional judgement, and they accept regimentation during their short stay in the institution.

Contrast the hospital to a nursing home, and you quickly realize what a different challenge a nursing home administrator faces. A nursing home is a flat organization. It has no notable hierarchy of professional and technical experts or middle managers. Because most caregivers are poorly educated, staff supervision and development become the administrator's major concern.

The needs of the nursing home residents also differ from those of the hospital patients and fall across a broad psychosocial spectrum. The nursing home is the last refuge for most residents; they are not transients; one in four will die there.[33] Incontinence is among their major problems. Two out of three residents are mentally or behaviorally impaired, and most are chronically afflicted. One in two require round-the-clock care. Many are mentally alert but simply too old and frail, but 13 percent of them are not even 65 years old.[34]

To add to the administrator's challenge, government regulation considers the residents as patients, and the nursing home as a scaled-down hospital. The community for its part holds the nursing home in little respect and allocates less than generous resources to it.

Nursing home management, therefore, calls for special skills and talent. We found that well-run nursing homes which give good care are

invariably run by managers with exceptional interpersonal skills suited for the task, the kind of skills they did not learn in management seminars, or pick up from "how-to" guidebooks. None of the administrators in the successful homes we studied walked into their jobs from MBA programs. They were teachers, insurance salesmen, pharmacists and pastors before they were drawn into long-term care. Some have now returned to school and secured the appropriate academic polish.

In the nursing home business, good managers are just plain smart. They are loaded with commonsense and TLC, so they readily learn from mistakes, their own and others'. They respect people; they know that you can motivate them better by recognizing their worth, by trusting their judgement and by rewarding their success, than by punishing their lapses and by breathing down their neck because you assume they take shortcuts.

The managers in our study ranged from the quiet, sober and colorless to the exuberant and determined. None of them was particularly charismatic, but each of them was enthused. They loved their work, they cared for their residents and they respected their employees. Everyone of them had that essential attribute of a good manager, a clear sense of purpose and direction, a good sense of priorities and balance, and at least a dash of good humor.

A. People's Managers

There are different ways to label the types of administrators we encountered in nursing homes. One convenient way is to distinguish the operations director from a people's manager. An operations director is a good organizer who schedules and coordinates services efficiently. He keeps his eye on the bottom line, he does all that the law requires, and he never misses a deadline.

The administrators whom we met in the best homes were all good operations directors, but they were more, they were successful people's managers. A nursing home, as we noted, is a unique service industry. Much of the care is menial bed-and-body work, and is given by lowest level of workers in health care. Its clients have a broad spectrum of long-term physical, medical

and psychosocial needs. Such an institution needs a people's manager, one who relates well to people, understands what motivates them and keeps them happy, and who is imaginative and flexible in finding solutions to the ever changing problems of staff and residents.

There are far too few good people's managers in the nursing home business, we found. There are not too many good operations directors either. Too many owners and administrators of nursing homes whom we met have a good eye for the bottom line, but have little vision, and even less interpersonal skills.

Much of nursing home management, we find, is crisis-oriented. When you have no sure long-term goals, do not really understand what nursing care is all about, and are deficient in people skills, you routinely precipitate crises: employee discontent, absenteeism and turnover; violation of codes, rampant infections and resident neglect. The state steps in and cites you for the breach of codes. Faced with penalties and closure, you marshal all your forces towards damage control. The game is won if you can keep the head just above water, and do just enough to get the state off your back. Then you cruise along and wait for the next crisis to hit.

Sadly, too many nursing home administrators in Illinois are not even good operations directors. They give inconsistent orders, change direction in middle course, communicate poorly with staff and give mixed signals to their employees. They expect loyalty, but do little to earn it. Too often they look for quick short-term returns rather than long-term investment. As a consequence their programs are not cost-effective, the staff talent is misallocated and skills are improperly used. They neglect resident families and pay little attention to public relations in the community. They are busy putting out brushfires that their erratic style constantly ignites.

The best managers whom we studied do not use the big stick approach, which according to management theory, follows the bureaucratic, authoritarian route. The manager who is cast in this mold likes organizational charts, formal rules and standardized ways of doing a job. He does not encourage role blurring and staff initiative. The best managers also steer away from the opposite extreme, the participatory style. In this model,

organizational structure is fluid, the administrator relinquishes much power and becomes a facilitator of staff initiative.

Nursing homes, however, have to meet the formal demands of regulatory requirements regarding licensure, documentation, distribution of tasks, etc. At the same time, it is a people industry. Its product is good care, its goal is staff motivation and resident satisfaction. Therefore successful managers steer a middle course, they follow a consultative management style.

Administrators who follow this style are good leaders because they provide an ambiance and a structure, but encourage informality. We found them sharing responsibility and asking loyalty and accountability in return. They nurture a rich exchange of informal relationships, communication, ideas and initiatives. They keep their ear to the ground and remain sensitive to any restiveness among the staff, residents, families and the community.

Jim Metzger, the administrator of Restmor, the Apostolic Christian nursing home in Morton, is a supreme example of the successful consultative style. Restmor was a proprietary facility from 1961 to 1978, when the Morton Apostolic Christian Church acquired and added it to the list of 11 other nursing homes which the Church runs in the U.S. The smartest thing the Church did was to bring Jim Metzger on board.

It comes as no surprise that Restmor is a QUIP six-star home. It is the first choice of the area hospitals and physicians. Physicians keep their own mothers at the home. His Masters-prepared social worker whom he hired in 1980 runs such a successful preadmission assessment and counselling program, that she is invited into hospitals and other nursing homes to give training and in-service.

"My management style? It is simple," says Mr. Metzger. "I don't suppress talent. I saw too much of that occurring at the hospital where I came from. It led to staff frustration, attrition and alienation. I was determined I would not be an authoritarian if I ever became a manager."

What is his strongest attribute? "My creativity; which means, I listen, see, get suggestions and learn. Employees have the best ideas how to lick any problem and how to improve care. I listen to those ideas, and I implement them. And I trust my staff. So I give them latitude, but hold them

accountable. They make mistakes, sometimes costly and risky ones. But then I have made a lot of them myself. Risk is the price, but the rewards are great: innovative programs, high morale and good care. So it pays off."

Jim Metzger is also a great operations director, punctilious and neatly organized, and one who always follows through on his word to staff, residents and families. He delights in numbers, and on the slightest excuse, and with relish, he will tell you his staffing ratios (1:6.1 for aides), per diem food costs ($3.10 per resident), the number of hours of volunteer time in feeding residents (3,500 in 1985), the number of prescriptions per month (6.1 per resident), and whatever it may be that you care to question him about.

If you are in search of Jim Metzger's professional look-alike, you should head 200 miles north to Wheaton, in DuPage County, where Ron Reinecke runs a model home which matches the Morton facility in excellence but in little else. The DuPage Convalescent Center, an outgrowth of a poorhouse built in 1888, is a 408-bed county facility where three out of four residents are public aid receipients and where Ron Reinecke does such a fine job that he boasts a waiting list of over 500 applicants.

Mr. Reinecke came to the Center twenty three years ago after a brief experience at a TB sanitarium. He is enormously successful at the complicated juggling act of keeping the county politics out of the facility but pulling in a generous subsidy, of maintaining high staff morale though the area is labor-starved, and of creating a homey setting for the residents in one of the largest institutions in the state. If you are looking for a felicitous blend of a people's manager and an operations director you don't have to look beyond Ron Reinecke.

B. The Marks of Leadership

How does a good manager function? We have sketched the profile of a successful manager. But it bears repetition. So we will highlight again the essential features that make up his style.

We discussed in the preceding chapter the need for a caring environment which is conducive to high quality. That is the prime

responsibility and the finest achievement of a great manager. A moral ambiance is not an ethereal concept. It is a concrete commitment to the care of the elderly. The ambiance which an administrator creates is in fact his unwritten statement of goals, his practical policy book, his concrete code of dos and don'ts. It tells the staff what the administrator values above everything, and the boundaries he sets which no one dare cross.

We saw good administrators articulate their principles consistently and repeatedly in a thousand little ways. We sensed his priorities when he invariably followed through on a family complaint; in his intolerance when an aide has neglected a resident a little too long; and when he engaged the residents in conversation at meals, activities and resident council meetings.

Indispensable to the task of nurturing a caring atmosphere is the second great achievement of an administrator. We noticed that every good home has a team of professionals who are of similar mind and attitude to the administrator's. The assistant administrator, the director of nursing and the heads of departments at these facilities were either carefully recruited, or have by now fallen in step with the administrator's goals and priorities. Their comfort level is high, they are fiercely loyal, and their longevity at the facility is impressive. "I could earn more money working at the Jewel," one Activity Director told us. "But I love it here, the spirit is great, and we are a family."

A nursing home is a people industry. Both residents and families are the clients, volunteers and visitors are part of the daily scene. Thus a nursing home routinely expects the unexpected to happen. Therefore a management team, with homogeneous ideas and a consensus on the essentials of care giving, is vital for success. Compatability makes for consistency. Consistency provides security. And security permits the staff to innovate, to experiment, to step outside one's role, to adjust and to accommodate to the unexpected turns in the nursing home life.

"Titles mean nothing when you work for Miss Mason," says the Administrator at Burgess Square, Ms. Jo Anne Fisher. "We all know what has to be done. So everyone pitches in. We serve meals, we wash the dishes, we change underpads. We are a team."

A third feature of good nursing management naturally follows: an

open door policy and a rich informality. Management by walking around (MBWA) was a term popularized by the best seller book on management, In Search of Excellence: Lessons from America's Best-Run Companies.[35] The book may have done a disservice. Many nursing home administrators mouth the term readily, but fail to understand the message behind. We have seen managers refer to MBWA to justify their unannounced tour of the floors to catch the aides taking a breather when their task is done. We observed one reprimanding on an aide: "If you have finished your job, don't sit around. Find something else to do."

MBWA is short hand for the informal ways in which managers mingle around with the employees to encourage, to reinforce, to pat on the back, and above all, to communicate. "Communicate, communicate, communicate. That's my motto, and that's our secret here," according to James Herbon of the Norwood Park Home. Like all good homes, Norwood Park encourages toll-free access to management, even to the Board of Directors. If the management shares a common view, the richer the interchange at all levels, the better the chance for a quality product.

A framework for informality and communication does not develop easily. At Restmor in Morton, Jim Metzger had a tough time when he took over eight years ago. He says: "I was here every shift several days for several weeks. I had to get to know the aides. They had to understand my concerns. I attended every meeting and in-service. I listened, they listened. I implemented a lot of their ideas. Now we are on the same wavelength. I have a highly motivated and loyal staff." "We encourage self-expression," says Jim Hebron, "and by God, we get it! Some of our best innovations in facility improvement came from the staff."

The Lake Bluff Health Care Centre, Lake Bluff, may have been giving good care but suffered a bad community image when the hearty Mr. James Bowden took over as Administrator. Beds were empty, the aides had a 50 percent turnover, their morale had sunk to the basement. "At first I went around with a lot of band aids. I plugged the leaks. I patted a lot of totos" reminisced the burly Irishman, who can turn one colorful phrase every second. His door is always open. He loves to give his "fatherly fireside chats." He

communicates and he listens. By all measures, he has succeeded in less than five years. His is a QUIP six-star home. Aide turnover is below double digit. Morale flies high. He has a long waiting list.

Pat Miller is the Director of Nursing at Lake Bluff. Petite, quiet and efficient, Ms. Miller exemplifies the MBWA philosophy. She is constantly walking the floors looking for any deterioration at the edges. Her sharp antennae pick up the faintest cues. Why is it that Mrs. Jacoby has not mentioned the aide's name in three days? Is there a problem in the making?

Ms. Miller tirelessly counsels aides on proper attitude. Sometimes the heart is in the right place, but a careless word has done the damage. Ms. Miller cites an example. "Mrs. Lukaszka came in one day to visit her mother. The mother was not on the floor. The aide told her to find her in the activity room. But the mother was not there either. Mrs. Lukaszka was very upset. In 30 seconds the aide may have conveyed an uncaring attitude and undone much of what we try to cultivate in family relationships."

A fourth distinguishing mark that sets apart excellent managers is the loyalty that they evoke from the staff. Nursing homes suffer from poor management, and therefore are plagued with a high staff turnover. One home we visited saw five Directors of Nursing go through the revolving door in two years, and now endures a 120 percent attrition a year among its aides. Distressingly, this is neither an extreme nor an exceptional case. All the eight model homes in this study, as we will elaborate in a later chapter, enjoy a negligible loss among their professional staff and a far-below-average erosion among their aides.

Good managers elicit staff allegiance by simply following the dictates of commonsense, which happen to be sound modern management theory. Humans are motivated not by fear of sanctions but by pride, recognition and rewards. Good managers give excellent fringe benefits and incentives, as we will note in a later chapter, and find it cost-effective to do so. But they do something more important. They take a positive view of their employees.

Good managers know that we all like to think of ourselves as winners. They may be intolerant when you breach their basic code. But they

are not out to offend your self-image by looking primarily at your poor performance. They rather concentrate on what you have achieved. They assume you are trustworthy and principled, so they give you the latitude to be creative and flexible in finishing the job. When you do, they are always there to pat you on the back and tell the others about it.

One less-than-successful administrator we talked to had a severe problem recruiting and retraining aides, and not surprisingly he typified the opposite attitude. He confided to us: "I can't expect responsibility from them, because they are not responsible in their personal lives. They live harsh lives and exist in a violent subculture. So I can't expect too much caring and tenderness from my aides."

In contrast, every manager of the successful homes talked to us appreciatively of their staff, and was embarrassed at the low wages they were forced to pay the aides. Rev. Crede, the Administrator of Sunset Home, Quincy, put it simply: "The aides fulfill the most important task in this nursing home. They should be the best paid in the industry." "I am proud that our aides care. They are proud when residents make progress." That is Jim Bowden again at Lake Bluff.

Haim Perlstein at the Northwest Home realizes that supervision and counselling of aides is a major issue in a nursing home. "I give my supervisors a free hand," he says, "and I fully back them up. We never reprimand an aide directly. We appeal to their pride and to peer pressure when a problem like stealing might crop up. It is amazing how well they respond. They take it personally and keep the delinquent in line."

Aides respond enthusiastically in a well-run home as we discovered from the questionnaires the staff anonymously answered for us in the eight homes in this study. With an astounding majority they tell us that their nursing home is the best or almost the best there is. Several of them have considerable experience in other homes. Again, with near unanimity they are satisfied or very satisfied at their work place. They think the management is great. They are considerate, they listen, they understand.

Excellent nursing homes are run by excellent managers. They are a breed apart, not because their style is esoteric or because they possess the

magic wand. But because good managers are, above all, very human; and they have good people skills. They are down to earth, full of commonsense and carry an open mind; and they learn quickly from conferences, from their workers, and from mistakes. They are caring and they are committed. They love their work. They respect their staff. They are concerned about the residents.

One good way we can sum up this discussion is to present three slogans we encountered when we visited different nursing homes.

- Successful managers are hard workers and efficient organizers. A plaque in the office of Jim Metzger proclaims his philosophy. "ASK FOR GOD'S BLESSING ON YOUR WORK, BUT DON'T ASK HIM TO DO IT."

- Good managers set high standards and instill pride. One member of the Board of Trustees at the Northwest Home has installed a marker in the kitchen. It instructs: "IF YOU ARE NOT PROUD OF IT, DON'T SERVE IT."

- Excellent managers are good leaders. They bring out the best in the staff, they evoke allegiance. In the office of Assistant Administrator of a nursing home, which did not qualify as one of our model homes, hangs a poster, which says: "A NEW INCENTIVE PLAN: WORK OR YOU ARE FIRED!"

CHAPTER 8

DEINSTITUTIONALIZING THE INSTITUTION: MAKING IT INTO A HOME

The nursing home serves as a home for a large number of our elderly, and for a sizeable number of them it will be the last residence on this earth. According to some studies, 39 percent of older persons will stay at least once in a nursing home, and 15 percent of them will stay six months or more; 23 percent will die in a nursing home.[33,36]

Seniors who live in nursing homes, however, deteriorate psychologically and die sooner than their counterparts in the community. That is the conclusion of Tobin and Lieberman, experienced researchers, who have studied the effect of institutionalization on the seniors.[37] Admission into a nursing home precipitates agitated behavior, depression and a poor self-image. Socially, a resident withdraws, becomes unresponsive and regresses into the past. Physically, one deteriorates as well: urinary tract infections, eye and ear infections, and bedsores are the most common postadmission diagnoses.[38] One in three die within a year after admission, another one in three dies within three years.[39]

Is the nursing home then a home, or is it a house of death, as geriatrician Robert Butler has described it both with authority and scorn? For sure, the damage an institution does to an older person partly amounts to a selection bias, that is, the seniors who enter the nursing home have unique problems to begin with. In part the damage is due to separation and rejection from family, and the stripping of one's identity even before entrance. Relocation itself, apart from the character of the institution, can also cause stress.[37,40] All this notwithstanding, mounting evidence shows how the nursing home environment alienates and dehumanizes the elderly.[4,41,42] Half of them will fail to adapt to its demands.[43]

Who among the elderly do in fact adjust to the new environment? You may be surprised by what researchers found. The wrong old people may be dying after entering the nursing home. The surly and paranoid survive, while the cheerful, cooperative and mentally healthy succumb.[44] There is one explanation of this odd finding. The new institutional context is so different from one's home, that this rude shock overpowers the happy, hopeful optimists. The suspicious and the hostile ones bluster on and smirk: "I told you so!"

To survive in a nursing home, it is necessary that the new life resemble the home life one has left behind. In old age it is crucial, researchers argue, that a move to a new place does not sacrifice continuity with one's past environment and one's control over the new setting.[45] Nursing homes, however, do not promise such a smooth transition, because they resemble a "total institution."

A total institution, in its classical description by Erving Goffman,[46] is antithetical to a home. As in the case of a jail, a hospital or an army, a total institution segregates its members from the real world, it sacrifices their privacy and regiments their life. A home, in contrast, is made up of a primary group—which is academic jargon for a small, closely-knit, emotionally bonded and unregimented group which assures you privacy, security and self-expression.

The model nursing homes included in this study demonstrate eloquently that institutional living need not be a depersonalizing experience for our elderly. They have succeeded in developing a home-like atmosphere which gives security, enhances autonomy, and fosters a rich, warm social exchange.

A. Reassurance from a Familiar Setting

If the house is one's castle, as the adage has it, it is because the home is a last bastion of personal dignity, intimacy, security and independence. An institution, in contrast, rests on an opposite principle. It seeks order, uniformity and formality. A nursing home in particular, as we have already noted, faces legal liability and professional risk by promoting the

independence of the frail and impaired residents.

Yet the successful nursing care facilities that we studied have walked the fine line skillfully. They have softened the rough edges of institutional living by providing continuity with the resident's past.

A feeling of security derives from a sense of belonging. You are secure when you are in the midst of the familiar world of family, friends and your own culture. Birds of a feather flock together for a very good reason. And so do we people, who seek out our own kind, the ones who hold our values, respect our tradition, follow our customs and share our perspective; because that is where we are comfortable, that is where our identity is affirmed, where life has meaning and the world is predictable. That is where we belong.

Ethnic ghettos and parishes have been Chicago's answer to the alienation and anonymity of urban life. These cultural ghettos are in fact homogeneous little urban villages providing a sense of community, meaning and security. Chicago area nursing homes have carried on this tradition as is evidenced by the British, Scottish, German, Norwegian, Italian and other homes in the region.

Good nursing homes display an unerring instinct for the sound principle of social psychology implicit in such a tradition. They try to replicate a cultural context within the nursing home walls which the residents can relate to.

Northwest Jewish home is an outstanding example. Its doors are open to all, but its residents are all Jewish—so rich is its Jewish culture, from its kosher kitchen, to the centrally located synagogue, to its Administrator—a fresh import from Israel. Only a few of the residents appear to be deeply or even seriously religious. But a sizeable number attend the rituals and religious readings. "As old age advances, one looks for one's roots, one's tradition, one's history. So we provide a rich set of experiences for them," explains Haim Perlstein. "We get tremendous participation."

Norwood Park Home has a diminishing number of residents with Scandinavian roots. So it celebrates a variety of ethnic festivals, Irish, Italian, German, etc. But it still preserves its dominant Norwegian slant. It is operated by the Norwegian Old Peoples Home Society, its Board of Directors is

mostly Norwegian in its backgroumd, and it keeps alive a vibrant Norwegian tradition complete with festivities for Lille Jul Aften, Syttend-Mai and Sankt Hans Fest, and its Scandinavian cuisine with Yulekage, Lutefisk and Flotegrot.

One way to nurture a congenial cultural feeling is to control the size of the facility. Every administrator admitted one wouldn't want to run a facility much larger than 200 beds. The Sisters at St. Joseph's were vehement. The Administrator, Mother Gertrude Mary, says: "The size of our facility depends on the number of nuns who can reside there. Yes, we have a long waiting line. But our values and philosophy are important to us. If we can't control the size, we can't set the tone."

At the DuPage Convalescent Center Ron Reinecke has no choice. He operates a 408-bed facility. "The secret is to break it up," he says. "In fact I run seven nursing homes here. They are almost self-contained units, with some autonomy, with some pride, and with some rivalry."

Another way is to make the resident population homogeneous. Every good home defines eligibility strictly. "We know our limits, and we know the problems if we don't set the boundary," says one administrator, reflecting the sentiment of others. "I will not mix the developmentally disabled with older people. There is nothing in common between them, in life styles, in care, in charting, nothing! For the same reason we don't accept younger people, psychiatric cases and alcoholics. Ours is an older people's home. We open our doors only to the seniors; we welcome even those who are very confused and severly impaired."

A third way is to rely on religion. Throughout history, religion has served as the focal center for human values and culture. Religion has embodied the highest human aspirations and mankind's greatest achievements. Researchers have shown that religion plays a vital role in the lives of the elderly. It provides them with a transcendent standard that gives meaning and purpose to their life, and promotes their well-being both physically and psychologically.[47]

Three of the homes in our sample are church-affiliated, and they preserve a heavy religious flavor in their daily routine. At Sunset Home in Quincy, the Administrator is a minister in the United Methodist Church. The

Home is affiliated with the Central Illinois Conference of the United Methodist Churrch. The Church runs 150 nursing homes in the country. Rev. Crede's style, demeanor and speech bespeak his religious bent. The residents respond to him accordingly, with reverence and esteem due to a man of the cloth who has their welfare close to his heart.

Jim Metzger at Restmor in Morton, is not a clergyman. But he speaks frankly of his fundamentalist Christian leanings, and how they motivate him "to take care of our own, both the residents and our employees."

In contrast to the Protestant homes, St. Joseph's Home in Palatine proclaims its Catholic culture loudly through its rich symbolism of religious statues, pictures and wall hangings, not to mention the traditional religious garb of the 16 nuns, ever present on the premises, the presence of 5 elderly priests among the residents, 3 Eucharistic celebrations a day (attended by residents and their families), and numerous other religious services and activities. The chapel at St. Joseph's stresses the primacy of religion in the home: it is the largest we have seen for a comparable home; it is centrally situated and generously decorated, and, unlike in other places, it is reserved exclusively for religious functions.

Scholars keep reminding us how important religion is in the lives of older persons. But if you really want to see what religion means to nursing home residents, you have to observe them, as we did, during a Eucharistic Mass. It was a facility in which a Mass had not been said in many months. In anticipation the room was filled to overflowing, and the occasion triggered off a wealth of sentiment. You could sense serenity, peace and ecstasy in the faces, in words and in behavior. The aides who attended were visibly moved. They had never observed such lucidity among some residents diagnosed as severly confused. A familiar religious experience had somehow brought back in them their real former selves.

We observed similar responses in a home with predominantly Catholic residents. A group of nuns garbed in fairly traditional habit were visiting. Their very sight evoked reverence and deferential gestures. Some residents held their hands and engaged the nuns in a long conversation. One very confused lady who usually speaks in garbled sounds was able to recite with little

help the entire Our Father, Hail Mary and Glory Be.

You find a rich tapestry of religious symbolism and activity in good nursing homes. These rituals help reconstruct the past for the residents, they provide reassurance for the future and thus regenerate the spirit. Nursing homes in some ways function as the respositories of religious culture of days gone by. The community may have forgotten the old ways, but at Norwood Park the residents taught the volunteer lay helpers how to conduct the rosary in group recitation!

The concepts of culture, religion and family were brought together on October 3, 1982 in a remarkable social event staged in Rome by the Little Sisters of the Poor. The occasion was the beatification by Pope John Paul II of the foundress of their Congregation, Mother Jeanne Jugan. Beatification in the Catholic Church is one step in the process towards conferring canonical sainthood.

As a rule nursing homes hesitate to take residents even to a ball game; the logistics of transportation, wheel chairs, crowds and toilets seem impossible. But typically the Little Sisters were undaunted, and went ahead with their grandiose plans. They drew residents from their nursing homes in six continents, including six from China and four from their Palatine home, and they meticulously orchestrated the operation, complete with color-coded shawls for residents of each country.

The dappled throng of hundreds of seniors with the Little Sisters all arrived in Rome in one piece. There they all knelt in St. Peter's Basilica in the Vatican, as the Pope proclaimed the beatification of their Founding Mother. They stayed on for a week for the grandest family celebration they have ever had. It is worth visiting St. Joseph's Home only if it is to look at the pictures in their family album and to catch the spirit of it all.

B. Being Secure and in Control when at Home

Home is where we are secure and independent. And you will find that the watchword in all good homes is security and autonomy. One may find it hard to get in, but once you become a part of the family, these homes make

you feel secure in a thousand practical ways. The most obvious is their bed-holding policy.

Nursing home residents are frail and in indifferent health. Many of them get transferred to the hospital for acute episodes. Their return is not assured in many nursing homes. This is not the case in the excellent homes we studied. Every one of them will hold a place for the hospitalized resident indefinitely and often even assure exactly the same bed that one occupied earlier. Private payors, by convention, will continue to pay the usual bed charge minus, say, $10, while Medicare may pick up their hospital bill. Those on public aid also remain assured of their bed, partly because the state demands that a bed be held for 10 days and pays a 75 percent per diem cost to a facility which has an occupancy of 92 percent or better, which is always the case with the better homes.

At some of the homes, we found, two beds may sometimes be held for one hospitalized resident, when they are unsure whether the resident will return to an "intermediate care" or "skilled care" bed. "We used to hold beds much before the DRGs, when hospitals sometimes retained a patient for what seemed an endless period," the Sisters at St. Joseph's Home told us.

For the Sisters, the comfort and security of the residents are paramount. Their waiting list may be endless, but they are also concerned that the transition may be too demanding for a new resident. So they host the new member for three days, and encourage the family to see firsthand how the home functions and if the person wants to stay.

Once the decision to stay has been made, you are very much a part of the new family. Following a hospice philosophy, the Sisters emphasize comfort and dignity and shy away from the high technology care that dehumanizes life. Even during the last days of one's life, the Sisters prefer to keep a terminally ill family member away from the hospital and to provide all physical and spiritual solace amidst the rest of the family at St. Joseph's. If the resident is forced to be hospitalized, they visit or call every day.

Although increasingly few deaths occur in the home and amidst the family, about one in five elderly die in the nursing homes, and many others do some of their dying there.[48] A hospital is designed to fight off death, but not

to ensure a good death. So too a nursing home, where much of the death and dying of the older persons occur. Most nursing homes do not realize what a significant issue this is for the residents. A conspiracy of silence prevails, and the staff is ill-equipped to handle matters of death and its effect on the survivors.

"We feel cheated if any of our residents should die in the hospital," says Mother Gertrude Mary of the St. Joseph's Home whose policy and approach ensure a humane, dignified end. "We prefer to be by the bedside, holding the hand, with other family members around." The Sisters were surprised to know that most nursing homes do not wake the deceased residents on the premises. All the homes of the Little Sisters of the Poor wake their residents, and always have.

The Sunset Home in Quincy also wakes their deceased in their chapel whenever the family agrees to it, but, in the Methodist tradition, refers to it as "visitation." In contrast to the Catholics, theirs is a somber affair, explains Rev. Crede. Currently Norwood Park also encourages waking in their nursing home. "We learned it from the residents themselves," Mrs. Lucarini, the Director of Nursing, says. "'We want to pay our last respects to our roomates,' the residents told us. We never realized what an in-home wake meant to the residents. Older persons have a more realistic view of death. They have lived long and know what life is all about, they handle death better than we thnk they do, and probably better than we can. They are a source of support and comfort to one another."

Sometimes the resident's family poses a problem. They prefer to wake the dead relative elsewhere, and may not consider how their decision affects the residents. A niece had her deceased uncle transferred from Norwood Park to a funeral parlor, paying little attention to the feeling of her aunt who had lived with her brother at Norwood Park for a few years. This sister of the dead person, being very confused, could not attend the wake. But she had been agitated ever since, and to this day she refers to the fact that she was not allowed to give the last respects to her brother.

A nursing home which sterilizes death tends to sterilize life. Many a nursing home scarcely pays attention to the important fact that most of their

women residents have been life long homemakers. Keeping a good home and setting a fine table was their career, their source of self-esteem, their accomplishment. Now they reside in an institution whose sterile atmosphere mocks at all they took pride in.

That is, however, not how the superior nursing homes function. They have an eye for the detail that adds the homey touch and the personal element. In those we visited, residents are surrounded by their personal belongings, from furniture to personal momentos, to individual telephones. The beds are always made; the bedspreads in some are quilted. The residents are always groomed, never in gowns, and often well dressed. These homes make meal arrangements and set the table in ways that replicate a home setting. At the Northwest Home fresh flowers appear on the table twice a week. St. Joseph's Home serves meals family-style, were the partakers serve themselves. At Norwood Park the staff sit down with residents for meals—and risk being cornered by a malcontent: "What about the light bulb you promised to fix, Lucy?"

A home that strives for a personalized setting also encourages personal autonomy, both in real and in symbolic ways. We observed how some homes hold resident floor meetings in addition to Resident Council meetings. At Norwood Park such floor meetings are lively and hilarious, especially when the confused residents have an equal voice. The administration says that these meetings have generated some of their best innovations, big and small: holding in-home funerals, grace-before-meals, seating arrangements at award sessions, the shape of the new windows.

At the DuPage Convalescent Center some residents have a garden plot that one is encouraged to cultivate, and residents themselves plan and coordinate all religious activity. At the Sunset Home a resident runs all the gardening operations. At Northwest, residents plan, manage and finance all the extensive operations surrounding the synagogue.

C. Permanence and Intimacy of the Family

Americans are a nation of movers. An average family picks up and

moves five times in a lifetime. Yet a home is where we have our roots; not in the residence where we live, but in the intimate world of those closest to us, where we let our guard down, recoup, and preserve our dignity. That is where we have our permanent bonds. That is where we know we belong.

What sets apart a good nursing home from an inferior one is that it succeeds in providing its residents this sense of permanence, intimacy and personal dignity. That is a significant achievement, given the constraints a nursing home labors under. Nursing homes are notoriously understaffed, and the nurse's aides are paid minimum wage or just above it. No wonder nursing homes rely heavily on mechanical and chemical restraints that strip you of your independence and dignity. Almost 20 percent of the nursing home drug bill is spent on tranquilizers.[12] Many nursing homes in the Chicago area suffer an almost total turnover of aides in a year, which in turn destroys any semblence of permanence in the social world of the residents.

Nursing home aides who leave the field and go to work for a hospice, talk disparagingly of the setting they have left behind. They find their new work dignified and rewarding where a sense of intimacy and community prevails. They say:

> "We treat patients different because it's their last time on earth. . . . We care for another human being. You don't have time to do that in a nursing home."[49]

> "We're not programmed. We respect patients' privacy and wishes. . . . The dignity you find in a hospice, the independence and freedom of the patients are not found too much in nursing homes."[49]

> "In a nursing home, most of the staff are not enthused about treating the people like humans . . . . If I gave them exercise the other staff would say: 'Don't get them in the habit because we don't have the time.' That's why I got out of nursing home care. You either had to be a part of them or get out."[49]

Kayser-Jones observed the enduring social bonds residents established with their care-takers in the nursing home she studied in Scotland.[41] That is what you also observe in the best nursing homes in Illinois. In the first place, such homes follow an ideology and a management style that dramatically cuts staff attrition, increases stability and makes possible lasting emotional bonds. Second, they foster a sense of teamwork and community that elicits and investment of self in the care one provides.

In home after home that comprise our sample, we observed remarkable comraderie and kinship between the staff and the residents. The staff bring their children to visit; they take the residents home; they take them on picnics and to shows; they visit them on their off days, bring presents on their birthdays, take their laundry home for a special wash, bring in their VCR to show a movie they know the residents will enjoy. In good homes the staff know the residents and their family well, they care about them, and they are attached to them.

We should note a special touch, which we observed in some homes, that adds to a homey feeling—the presence of a dog mascot. Four of the homes in our sample had such a mascot and all of them had animal programs.

The therapeutic role of pet animals among the elderly has been well established.[50] Pets stimulate alertness, responsiveness and inquisitiveness both in geriatric patients in hospitals, and in nursing home residents.[51,52] One study at the University of Pennsylvania Hospital stumbled on to a remarkable finding. They followed patients who went home from the coronary care unit in order to determine who survived after a year. Pet owners did, and at an astonishingly higher rate than those without animals.[53]

Four types of animal programs are common: 1) nonscheduled animal visits, 2) scheduled animal visits, 3) resident animals, and 4) animal-facilitated therapy. One survey showed about 69 percent of Minnesota nursing homes now use, or have used, pets.[54] No such figures exist for Illinois. In one Chicago nursing home we know, a resident takes care of Fido, the dog mascot, who each morning makes the round of all the residents, many of whom look forward to Fido's visit.

Yet another feature that simulates the warmth of a home

environment, we discovered, is the presence of children in the nursing home. Many good nursing homes across the nation arrange programs, including child day care, that bring children from infant age to eighth grade into the nursing home.[55,56] The children, their parents, the residents and staff, all report enthusiastic support for these in-house and outdoor integenerational activities. Time after time, it has been observed, Alzheimer's patients become less agitated and enjoy moments of lucidity in the presence of children.

Most of the better homes in Illinois consciously draw children into the lives of the residents, through exchange programs with nurseries, through adopt-a-grandparent programs, through the pre-Confirmation service agreements with Catholic churches and many other innovative ways. The residents often look forward to the children's visit, they distribute candy and gifts, they invent games for them, play and eat snacks with them and go out for walks.

A discussion of social intimacy cannot ignore the role of sexuality in nursing homes. All nursing homes seem to accommodate married couples, but even the better ones may not pay enough attention to the heterosexual dimension of social life among the elderly.

Too few discussions distinguish sex activity from the notion of sexuality. Sexuality connotes friendship, companionship and closeness between the sexes, which the elderly may desire more than sexual activity. It also emphasizes, for women for example, the desire to be and to appear feminine and attractive—well groomed, with the hair done, the face prettied up and wearing a nice dress. The good homes pay attention to this, but not enough and certainly not consciously enough.

Nursing home management and staff generally reflect society's notion that sex is appropriate for younger persons, but somehow is dirty when you are old. Our tales fancify the decline in sexual activity with age.[57] There is the story of the band leader who draws from a repertoire of songs to play at wedding anniversary parties. On the first anniversary he plays "Night and Day;" on the fifth he plays "Saturday Night Fever;" for the tenth he plays "Once in a While;" for the twenty-fifth he plays "Now and Then;" and for the fiftieth he leads a refrain of "Thanks for the Memories."

The residents in nursing homes, in addition to the staff, do not always take kindly when two persons pair off. In one of the homes we visited, a near-blind man on a wheel chair was always helped and escorted around by a woman. Sadly, that close companionship came to an end and left the man visibly shaken and depressed, when the floor chatter became more than his lady friend could take. Nursing home tattle is as potent as the neighborhood gossip: "Mr. Maganck and Mrs. Keenan are in there again holding hands and sipping wine!"

We should end on a happy note. At St. Joseph's Home Mr. and Mrs. Schiffer are preparing to celebrate their fiftieth wedding anniversary. Mr. Schiffer is 87 years old and has a slight problem in his ankle; Mrs. Schiffer is a petite, spritely and very feminine looking 80-year old. We visited them in their large room elegantly outfitted with their personal furniture and belongings. Mrs. Schiffer was completing the long list of guests who will be invited. She offered us Fanny May candy and explained: "The Sisters keep pushing me to add more names. 'Go ahead and invite the whole world,' Mother Gertrude keeps telling me, 'this is a once-in-a-lifetime celebration. You deserve it. We will celebrate it with you.'"

CHAPTER 9

OPENNESS TO THE COMMUNITY: THE WATCHDOG OF QUALITY

Excellent nursing homes all take the same stand towards the community. They keep their doors open, and they invite the community in, to see what is going on, and to become a part of their life. In the nursing home business one fact is clear, and it speaks for itself. When the community gets involved in the nursing home, the quality of care improves. Enough studies have now documented that simple fact.[58-60]

At the inner core of the community lies the resident's family who cares about the quality of life in the nursing home because it affects their loved one who is placed there. Beyond that core is the vast array of volunteers who visit, help, serve and advocate. Finally there is the professional community that offers specialized services which a nursing home needs: the churches, the hospitals, the colleges, the beauticians, the dentists and others.

The presence of the community in the nursing home leads to better care because the community serves as the informal watchdog of quality. In a highly changeable social world of the nursing home, the community provides some continuity for the residents. It becomes the advocate of their fragile rights. It supplements the facility's scarce resources and helps to improve its image and relations with the outside world. Excellent homes give good care in part because the community is very involved in their life.

A. Families as Partners in Care

Few nursing homes realize that the family is an important part of their total client. Rather, they see the family as a hindrance. "They carry around a bucket of guilt," one administrator complained to us. A Director of Nursing put it bluntly: "If we could get rid of the families, we could go on with

our own work here."

However, a nursing home can ignore the family only at its own peril, and only at a heavy price: quality of care declines, a valuable resource is wasted, public relations suffer and a ready marketing tool remains unused.

Nursing homes forget that in an overwhelming number of cases it is the family who decides on institutionalization. The elderly themselves may participate only marginally in that decision.[34] But that decision traumatizes most families. It leaves deep emotional scars.

The problem is common. Outside circumstances have forced the family's hand, but the family still feels somehow responsible for sending away mother to the nursing home. Mother may have begun to slide, in mind or in behavior; incontinence and sleep disturbances are getting worse. And the family is already under pressure due to disability, divorce, work demands and financial burdens. It does not understand the aging process and mother's sudden deterioration; it denies that death is approaching.[61,62] Putting mother in the nursing home, therefore, adds to its anxiety.

Despite what the popular myth might say, we do not dump our older relatives into nursing homes. Families in fact keep up their contact and visit the nursing home over a long period of time, as researchers keep reminding us.[63] But families also bring their anxieties along and create problems for themselves, their dear one and the staff.

A third of all families are troubled and are in serious need of nursing home attention and counselling.[64] Among them you will notice the "avoiders" who visit only as much as their guilty conscience demands, and the "compulsive visitors" who drown their guilt with frequent visits. Both these complain about nursing home life, but the problem may lie in their troubled soul rather than in any bad experience at the facility.

Still, an agitated family disturbs the frail psychosocial world of the resident. It lowers morale, increases dissatisfaction, disrupts the care process, and, in a ripple effect, troubles the other residents and disrupts the nursing home life.

The staff also gets drawn into this negative cycle. The family's guilt and distress do not go unnoticed by the staff, but they hardly feel responsible

for it. Rather, they resent the unnecessary interruption. They wish the family was more sensitive and realistic, and did not expect prompt, one-on-one care to the older relative. They wish the family got out of the way.

That completes the negative cycle. The family-staff-resident interaction is seriously flawed. And the problem feeds on itself. It builds the frustration level of all parties and hinders the therapeutic goal.

Every excellent home we studied has succeed in breaking that vicious cycle. As a first step, these homes accept the family as their "other client." They bank on the family's willingness to get involved. And they are right, for over four out of five families do wish to get involved in nursing home programs.[65] Others want to meet with the staff, take courses on aging, or get advice on how to make the visits more pleasant.

Excellent nursing homes are concerned about the families and show their concern in practical ways. At the Northwest Home the staff knows each family. And you will find that the Administrator spends what might seem to be an inordinate amount of time with them. Remarkably, you discover that, with variations, this is also true in every one of the successful homes in our study, all the way from Quincy to the south to our northern most home in Lake Bluff.

Even more impressive to see is how successful homes translate their concern into effective family programs; with a sure instinct they base these programs on a sound approach. One researcher in Minnesota found that if you use the family to help supplement services to the relative, you may be in a worse shape than if you ignored the family.[66] The family shies away and withdraws when your programs assume that the resident is sick and dependent, and you ask the family to pitch in. On the other hand, the family responds well when you treat the family itself as a client, when you assume that the family also has needs just as the resident does, and you encourage both parties to meet each others needs.

That is the approach towards the family at Burgess Square. The family and residents both participate in the two-day conference following admission. The entire care and rehabilitation plan is cojointly developed during that conference. Burgess Square has discovered that such participation relieves the family's anxiety. "They feel secure," the Administrator told us, "and the

resident makes a smoother transition and adjusts well. Do you see this constant stream of families and relatives here? They are a part of our life now."

Burgess Square is not alone. All the superior homes in their own way have included the family in the care team. We discovered that, formally or otherwise, they addres the family's guilt, they counsel the family about their sense of failure and inadequacy. If families feel secure and show an attachment for the home even through generations, as they do at the Northwest Home, it is because the management's concern for the family is shared throughout the facility. It has become a facility-wide approach. Staff orientation, training and in-services reflect that approach.

If the family is your "other client," then you have to keep your client informed. All good homes know that; so they have devised ways to notify the family of any changes in the resident condition. They encourage unlimited visitation, they provide private areas for visits, they help the family to celebrate special events at the facility and to take the residents out.

All successful homes have newsletters and brochures. Some of them use special programs, guidebooks and filmstrips that teach family members about aspects of aging and giving care, especially when the residents return home. They encourage the family to get to know the staff and to conference with them. They involve the family in planning their own special events.

You will find that every good home is different. Each one has developed its own identity, character and tone, because each home relies on a rich informality between staff, families and residents. They take every excuse to throw a party and expect all to join in. They encourage families to share dinner, especially on festive occasions.

Each home adds its special touch. Restmor in Morton, for instance, holds a gala mother and daughter banquet on Mother's Day. You may invite a special friend if your daughter cannot make it. It is indeed a festive, and touching celebration of motherhood.

B. The Community as a Resource and Advocate of Quality

Beyond the family stands the larger community. The community is

concerned about its senior citizens, but is disenchanted with the nursing homes. 28 percent of the people say they would not go to a nursing home under any circumstances.[67]

Still, the community can be the nursing home's best friend and its most valuable resource, as we learned from the example of the better homes. Naturally, therefore, the famed Institute of Medicine study on nursing home quality strongly advocates that the community be involved in nursing home life.[68]

When invited in, the community supplements the functions of the regulators. State inspectors drop by only periodically, and they inspect care only partially. The community, therefore, serves as the informal watchdog, since visitors remain alert to lapses of care, concern and courtesy.

Staff turnover in an average nursing home is alarmingly high. Its aides are undertrained and overworked. Part-timers and agency aides are its regular feature. Little wonder that continuity of care suffers, resident-staff relationships wilt, and residents risk neglect and abuse. Therefore community presence serves as an anchor of security for the residents, their shield of defense and an assurance of some continuity and concern.

Being frail, widowed or childless condemns many residents to loneliness and to little self-protection. They are too vulnerable to influence staff attitude. The regular visitors, however, carry the residents' requests and complaints to the outside world. The community becomes the defender and advocate of the residents' fragile rights.

All evidence, therefore, points in the same direction. When you put out the welcome mat and invite the community into the nursing home, the residents' quality of life improves.[58-60] But, if the badge of mediocrity is what the nursing home industry wears, it may in part be because it has kept the community at an arm's length.

However, nursing homes do not shut the community out altogether. One survey showed that 84 percent of homes have a volunteer program, and 96 percent have volunteers come in.[69] But as you might expect, here is the rub: the majority of volunteer programs in nursing homes are token gestures; they involve less than ten members.

Not so in the best nursing homes in Illinois. Every home we studied has cultivated a varied corps of volunteers, even the proprietaries. At Lake Bluff, a for-profit home, the volunteer programs are so full and extensive, that a full-time coordinator recruits and orients the volunteers and orchestrates their services. Volunteers improve the tone and quality of care; but they also increase profits. One cost analysis fo 43 proprietary homes simply concludes: "Profits rise where volunteers are integrated into nursing home services."[69]

You could pick any home in our sample and hold it as a model for the lesser lights in the industry. Take the DuPage Convalescent Center, for example. Its volunteer roll adds up to 400 names! You will observe 300 of them very actively involved in every phase of the nursing home life. 25 separate community organizations provide varied services. High school bands perform at the facility. Civic groups provide entertainers, performers and accomplished speakers.

The DuPage Center is open for visits 24 hours. Friendly visitors are always present. Several families in the community have adopted residents who have no family of their own. They feed them at meal time, bake pies for them, and take them out for shows, performances, games and picnics.

At Restmor volunteers help out even in the business office. One gentleman prepares the time cards for payroll. Three ladies deliver mail. Two others do the billing. On one of our visits we observed a group of ladies from the community sitting with some residents and engaged in lively conversation. This is a group of accomplished quilters, we discovered, who find it congenial to ply their skills in the company of oldsters, some of whom were consummate craftsmen in their younger days. The group produced 115 quilts last year and donated all the profit to the home.

You will notice, as we suggested in the previous chapter, that good homes like to have children in their midst. Once you make them feel at home, children relate beautifully to older persons. At the Sunset Home in Quincy sixth graders adopt grandparents. We saw preschoolers from the local day-care center visiting with the residents. We found that residents eagerly wait for the arrival of the kids, they have collected candy and presents for them, they are eager to tell them a new story.

Burgess Square has an exchange program with the neighboring day-care center. One month the children drop by at the home, the next month the elders visit the children at their center. If you want to see a creative intergenerational exchange, you should watch the children and the seniors at Burgess Square sitting across a long table together inventing a picture story with crayons and sheets of paper. First, it is the child's move, then the older person adds to the sketch, and then the child comes back with a totally unanticipated leap of the imagination. And that's how it goes, two ends of a generation, partners in building a common world of fantasy.

The Northwest Home has established such firm links with the community, that volunteers remain loyal through many years. The volunteer tradition stays with a family through generations. Children whose parents once lived at Northwest, continue to volunteer services even after the parents' death. At Norwood Park the Board of Directors themselves personally give of their time and services.

The local churches and religious organizations are heavily involved in every one of the good homes. They conduct religious services, rituals, readings and a wide spectrum of activities on the premises. The nondenominational homes understandably provide a larger choice to their residents. Most often residents themselves help plan and coordinate the religious activities.

We should note one imaginative program which is catching on. Lake Bluff is a case in point. St. Mary's Church in Lake Forest requires that Catholic youth preparing for the Sacrament of Confirmation do some pre-Confirmation community service. This year these thirteen- and fourteen-year olds came to the Lake Bluff home for two hours each on five Saturdays. The youngsters escorted the residents to and fro from dining rooms, did chores for them, took them for a stroll, gave them private sing-a-longs, and in return learned what it means to be a ninety year old, and about the colorful highlights in the life history of hundred year olds.

During the last Christmas season 200 eleven-to-fourteen-year olds conducted a four mile "walk of love" to the Lake Bluff home. The ground was covered with snow and the wind was cruelly cold. But the candle-lit procession of youngsters trudged along singing high pitched Christmas carols. Once at the

home, the intergenerational celebration was a joyous event with lots of hugs, kisses and presents.

Better nursing homes also seek linkages with the surrounding colleges. We found that several college-based nursing and nurse's aides programs conduct classes and internships at the homes we visited. Several other professionals in the community are also involved in these nursing homes. Podiatrists, dentists and ophthamologists donate their time. At St. Joseph's Home 12 beauticians each donate half a day every week to the residents.

As the community recognizes the commitment of the good homes and the devoted care they give, it responds generously in time, service and money. The Sunset Home in Quincy has been the beneficiary of several bequests. The Christian Apostolic Home in Morton also receives gifts through wills, legacies and church donations. "The community has been very generous, and we have never had to fund raise on a regular basis," says Jim Metzger, the Administrator. In fact, during a renovation program Mr. Metzger went to the community for $350,000 in matching funds that he needed. In less than two months enough pledges came in to overshoot the mark.

"I never worry about money. I concentrate on quality," says Haim Perlstein of the Northwest Home. He recently started a half million dollar remodeling and expansion program without knowing where the money would come from. But it did come in, all of it, and the ground was hardly even broken.

The community is also very generous to the Little Sisters. Every type of lay volunteers and professionals donates generously to St. Joseph's Home. The Sisters also go out with their begging basket, and their admirers always see that it is filled. Retail stores, food stores and manufacturers give generously. Even drug companies send in some pharmaceuticals they need. Every year the Sisters raise one and a half million dollars to meet their operating costs.

In sum, it is true that the community remains skeptical about nursing homes. But the community also appreciates when the good homes go all lengths in caring for the frail elderly. It is a reciprocal generosity. The superior homes are dedicated to quality and they wish the community to come in to see and to

help. The community responds generously with all its resources.

Good quality makes good sense. Because quality pays—in self-satisfaction, in public appreciation and in the community's generosity. Thus, good homes seem always to celebrate. Families, friends and volunteers are constantly with them at receptions, mother-and-daughter banquets, silver gown balls, Hawaiian Luaus and endless other festivities. Good quality deserves to be celebrated.

CHAPTER 10

THE CARING CAREGIVERS: AN INVOLVED STAFF

All of us play the status game. And since health care professionals are no saints, you find them too in the same ball park. Among the physicians, the surgeon plays the top dog and receives substantially higher social and economic rewards compared to a general practitioner, who invariably is your nursing home medical director.

The nurses maintain their own pecking order. Even among RNs, the medical-surgical nurse holds the high ground and looks down on, say, the public health nurse, who in turn turns up her nose at the geriatric nuse, especially the one employed in a nursing home.

Although the market has tightened, few nurses are seeking employment in a nursing home. As it is, you find few registered nurses in a nursing home, and when you do find one, almost nine out of ten times she does not hold a bachelor's degree. If a facility employs a hundred nursing personnel, only 15 of them will be registered nurses, another 14 will be licensed practical nurses, and the rest, a big crowd of 71, will be nurse's aides.[70] In Illinois that crowd swells to 80.

It is these aides, coming undoubtedly from the bottom of the health care labor pool, who provide the actual care to the residents—six times as much as do the registered nurses, and five times as much as do the licensed practical nurses.[70]

Comparisons, therefore, become decidedly odious when you realize that nursing homes have the highest ratio of service workers in the health fields, but the lowest ratio of professional and technical workers. Nursing homes do not run on premium gasoline: three in four of their workers are unskilled; only one in ten has some specialized skills, and even that somber statistic is predicted to worsen in the future.[71]

So the nursing home administrator faces a severe test: how is one to assure high quality of care, given the less than impressive caliber of one's staff? It comes as no surprise, of course, that most nursing homes do not make the grade. Their staff is untrained, overworked, underpaid and unmotivated. A constant stream of aides flows through their revolving door. Ultimately their residents end up paying the price: discontinuity, insecurity and neglect.

Does anyone meet this challenge successfully? Yes, indeed, the good nursing homes do and with considerable success. Although they face the same labor market, excellent nursing homes achieve excellence because they approach their staff differently than does your average home. They create a motivating climate for them and they transform their employees into caring caregivers. You find that the staff in these homes are involved, they are loyal, they take pride in their work, they care, and therefore they give good care.

Transforming an indifferent staff into good care providers is not a success that comes easily. All homes, good and bad, face quite a task in recruiting, training, motivating and retaining employees to perform menial bed-and-body work day in and day out. It is a formidable task, but not an impossible one. Nursing homes of all stripes—proprietaries and voluntaries, religious, secular, those with a venerable tradition and those with none—all show convincingly that with some imagination, good management and a decent benefit package any administrator can attract and retain good workers, provide excellent care, and still come way ahead on the balance sheet.

A. Professionalism and the Labor Problem

Nursing homes are today where hospitals were a generation ago. Nursing homes suffer a tarnished public image; they can hardly boast a high professional standing; their management lacks much sophistication. There are of course outstanding exceptions to the rule—the eight remarkable homes in our sample are refreshing proof—still, by any standard of professionalism the industry limps, and limps badly.

The problem starts at the top. The industry has both failed to demand high standards of itself and not policed its shoddy practices. In 1962

the American College of Health Care Administrators, then known as the American College of Nursing Home Administrators, established a credentialing system for membership—experience, education and continuing education. In 1969 the National Advisory Council on Nursing Home Administrators recommended that administrators take a national licensing exam, receive a Master's degree by 1980, take continuing education and get supervised clinical experience.

In 1971 the federal government stepped in and mandated a licensure of nursing home administrators. That has proved to be a historic step. No other health occupation has ever been subjected to a federally mandated licensure law. The law evolved out of external pressure. Naturally the nursing homes have given it scant support.

Worse, individual states were allowed to develop their own licensing standards for administrators. That opened the door for industry lobbies to win local concessions denied them in Washington. Out of these local skirmishes evolved a kaleidoscope of requirements and norms. Today only some states require a bachelor's degree for their nursing home administrators; some require little education beyond high school. Internships vary in length, the skills and knowledge of preceptors differ as well. Continuing education requirements are not standard among states.

Few administrators today are educated in their field. Most have developed an adaptive behavior to state mandates which keeps them safely on the right side of the law, but still skirts the principles of professionalism.

Thus, superior training, expertise and professionalism do not seem to be the stuff the average manager is made of. And the problem that ails the industry at the top affects also the rest of its operation. Distressingly, it particularly afflicts the lowest level, the world of the aides which, more than any other, shapes the quality of life for the residents.

There is little doubt that nursing homes that hire more and better qualified nurses give better care.[70] Yet, nurse-to-resident ratios vary widely in states, from as little as 0.32 nursing hour per resident-day in New Hampshire to as many as 4.0 hours in Hawaii. Illinois demands 2.5 hours for skilled care and up to 1.7 hours for intermediate care.[72]

In regards to the number of beds per licensed nurse, states differ as much as 400 percent. While Oklahoma lags behind with 18.8, Arkansas leads with 4.5; Illinois hobbles along with 12.7. The RN/LPN ratios vary nine-fold, from a low of 0.2 in Texas, to 1.2 in Illinois, to 1.9 in New Hampshire, the highest in the nation.[73]

The nurse's aides tell a gloomier story. These are workers who provide 90 percent of the care in a nursing home, and largely make up the social world in which the residents live. Yet only 17 states demand any training programs for them, and these too vary widely. California, with 150 training hours, requires the highest number, Illinois mandates 120 hours, whereas Nebraska a meager 20 hours. These 17 state programs follow no consistent educational content, goal, organization or relationship to the actual work of the aides.[74]

The picture that emerges in the larger view is hardly flattering. If you have to judge by the canons of professionalism,[75] the nursing home industry scarcely measures up in matters of higher training, expertise, dedication and self-regulation. Take self-regulation. The Joint Commission on Accreditation of Hospitals (JCAH) has offered nursing homes an accreditation program since 1966. The process is voluntary. It aims at quality assurance through peer review, professional responsibility, education and consultation. Yet only 3 percent of free-standing nursing homes participate and have received accreditation.

On the state level the industry has balked at efforts to raise quality and professional standards. One example is the 120 hours of required training for nurse's aides in Illinois. The state mandated that requirement even against a stiff industry opposition. As it is, any person can obtain a license to run a certified nurse assistant program. Thus, many for-profit store-front operations flourish around the state.

These then are the troublesome odds against which the success of the better homes has to be gauged. Good nursing homes face the same labor problem as do the poor ones. Yet they attract and retain superior workers. These homes give excellent care to the residents because their staff are committed, loyal and caring.

The achievement of good homes is exceptional not because of any exceptional circumstance that favors them. Our sample of superior homes amply illustrates that it is not their size that makes the difference, nor is it their denominational character, nor their case-mix, nor their setting. Despite all these differences, these homes have a stable staff who tell us a consistent story: they enjoy their work environment and they love the residents whom they care for. Two homes in our sample have unionized employees, but even that feature does not alter the picture. We found their staff as loyal and as satisfied as in the rest.

B. The Cost of an Unstable Staff

A heavy staff turnover plagues the nursing home business. The manufacturing industry suffers an annual attrition of 50 percent, while the service industry normally loses 22 percent of its workers in a year. These statistics, however, seem comforting when you consider the 69 percent staff erosion in nursing homes.[76]

This national average is less benign than it appears, since it hides a grim reality. In California, annual nursing home staff loss has ranged from 75 to 400 percent.[77] In Minnesota it has hit as high as 728 percent.[78] One researcher has documented that in a sample of 19 Minnesota homes 45 percent of the aides left within the first 3 months, and an additional 30 percent left before the first year was out.[79] In two Chicago area homes, not included in our sample, we found an aide turnover of about 130 percent a year.

This massive hemorrhage afflicts the nursing home business so widely, and it appears so endemic, that many homes accept it as normal. They do not expend the time and energy to stem the tide. Rather they take comfort from the small core of employees that hangs on; they mistake it for loyalty and fail to detect the common apathy below the surface.

You have scholars who try to put a good face on the turnover problem. The Postal Service and railroads, they argue, are clear proof that employee turnover is not necessarily bad. These industries have a very low

turnover, but they run a very inefficient operation.[80] Others point to the hospitals. The nurses that leave hospitals are poor performers, they say, and they lack interest and motivation to hang on.[81]

None of these scholarly disquisitions, however, illuminate the meaning of the nursing home staff exodus. Both management and nurse's aides will tell you that turnover cannot always be blamed on the managers. For an ambitious aide, the nursing home often serves as the first stepping stone to a brighter future. Nursing home employment provides her with supplementary income to help attend college on the side; she may be testing the waters and developing contacts for a career in health care. An enlightened manager accepts all this; and may even encourage the aide to pursue her lofty dream.

Still, a constant staff outflow leaves severe problems in its wake, unless the management handles it deftly. Much of nursing home care includes dispensing of medication, grooming, diet and rehabilitation. Such care suffers when aides leave and take with them the knowledge of residents' idiosyncracies, habits and medical conditions.

A constant turnover also disrupts the social world of the residents, and makes it difficult for personal relationships to develop. In 1985 the National Citizens' Coalition for Nursing Home Reform went to over a hundred nursing homes in 15 cities and asked residents what they considered to be good care. The residents, it turned out, prized highly how well qualified and competent the staff are, and, significantly, how cheerful they are in disposition and how friendly when they deal with the residents.[82]

Then there are the dollar costs. When employees leave, you face added costs because you have to recruit, to interview, to orient, to supervise, and to keep records. You also use other personnel to help the new recruit, you pay for overtime and for agency replacements, you expect low productivity from the new hands. Thus hiring a new aide can cost as much as four times the old aide's salary.[77] One study in Minnesota attempted managerial interventions and found that one nursing home that cut its turnover by 66 percent, saved $166,400, and another that suffered a 16 percent increase in staff loss incurred an additional cost of $128,000.[79]

The average nursing home endures a heavy turnover and pays a hefty

price for it. But consider the record of the homes we included in this study. They experience little slippage of middle managers—the directors of nursing, activity, social work, housekeeping, etc. As Appendix A. V testifies, department heads at these homes have served an average of 5 to 10 years.

Neither do these eight homes lose many of their professional nurses. Half of these facilities lost 4 percent of these professionals this past year. Two others suffered a 10 percent loss each. Burgess Square has operated for less than two years under the new management, and is still completing the task of building a like-minded team. So it let go 20 percent of its professional crew. The Sunset Methodist Home, however, was hit by a 66 percent loss this past year. That was clearly an aberrant year. The Sunset Home compared well with the rest in our group, till the sky fell in last year. The Quincy area economy nose dived, unemployement soared and many left the region in search of greener pastures.

Behind these general averages lies an even more heartening picture. Take DuPage Center. Its experience is typical. The Director of Nursing has stayed on for six years. The previous one retired after a service of thirteen years. The Assistant Director is completing her fifteenth year at DuPage. Almost half of the professional nurses have worked there for over 5 years, and half of these for over 10 years.

However, excellent homes outshine others especially in holding on to a loyal group of aides. Their attrition rate falls considerably below the average for area homes.

But consider especially the case of four homes in our sample; they bring home an important point. Burgess Square and Lake Bluff, both proprietaries, along with Restmor in Morton and Sunset Home in Quincy, two church-related homes, all provide proof positive that the aide turnover is not an intractable problem.

These four facilities changed ownership or management in recent years. The new hands inherited no enviable tradition. All faced a massive staff hemorrhage. The new management barely invested added resources, but they did change the style of doing business, and before long in each case the situation turned around. Today all the four homes enjoy an enviable position.

They are models of care, and they are all staffed by a stable, dedicated and caring team of care givers.

At first sight, the Sunset Home again stands out as an exception. Nearly half of its aides exited last year, a lower than the national rate for sure, still unusual for an excellent home. It is likely that Quincy's unstable economy may have precipitated the problem.

Even at St. Joseph's Home and at the DuPage Center about a third of the aides left last year, again a surprising loss for such well-run facilities. But you should dig deeper. What you find is a pleasant surprise.

Let us illustrate with the case of the DuPage Center. 68 percent of its crew of 149 aides have stayed on for over a year, and almost 1 in 5 for 5 years. We dug even further. We questioned a random group of 45 of their nursing staff—35 of them were aides—about their feelings about the home. A striking 96 percent of them told us they were satisfied; a little less than half of these said "very satisfied!" More than 3 in 4 consider the facility the best there is, and 1 in 5 finds it better than most. They should know: three fourths of them have worked in other nursing homes.

The DuPage Center suffers a slight aide retention problem despite its superb management and good pay—$5.10 an hour to start with, and a substantial benefit package. The root of the problem appears to be its location. The township of Wheaton, where the home is located, lies 30 miles due west of Chicago. It is effectively cut off from any access to public transportation. The County of DuPage, in addition, enjoys among the nation's most explosive economic growth. That good furtune, however, has spawned a labor shortage. The nursing home has had to compete unfairly for labor against the booming stores and industries in the area.

Labor competition and transportation do pose a problem for St. Joseph's Home and the DuPage Center. But distance alone does not deter aides when they find a congenial nursing home to work in. We were properly edified at Norwood Park and at Northwest to find that some aides travel 60 miles round trip each day to get to and from work. Like the staff at the DuPage Center, the aides at these two homes are strongly loyal, very satisfied and they overwhelmingly vote their home to be the best there is.

C. Solicitude for the Aide

Employee turnover is the bane of the nursing home industry. Still, strictly speaking, turnover is not the real problem of nursing homes. It is merely a symptom of an underlying, unwholesome malaise. Turnover results when a nursing home lacks a motivating climate. And failure to motivate simply amounts to a failure of management.

During the course of our investigations we have observed administrators rudely awakened to an intolerable loss of staff in their homes when it has resulted in an obvious decline in care and has alerted the state inspectors. Crisis-minded managers typically respond to the most obvious deficiency. They shore up efforts at recruitment, install a crash training program and offer monetary incentives to cut staff loss.

These tactics amount to band-aid efforts, because they fail to understand why it is that aides jump ship in midstream. Financial rewards, for instance, can scarcely dent the problem of sagging aide morale. Monetary benefits make a difference only when they express the support and concern of an enlightened management.[83]

Excellent nursing homes, whether consciously or not, illustrate the best principles of modern long-term care management theory.[5,76,77] Any good administrator will tell you that the aide turnover problem is a problem of morale. Human motivation and morale can scarcely be sustained merely on financial incentives. Good managers understand that if you nourish your aides' self-esteem, recognize their worth and appreciate their work, you will receive loyalty and devotion in return. So they go about setting up a system which remains sensitive to their personal problems, respects their emotional and social needs, and values and rewards their contribution. Such a system makes aides into caring caregivers.

To begin with, good managers understand, and therefore, show concern for the world from where the aides come. And it is a harsh world. We met with a class for nurse's aides held at a Chicago area community college. The majority of the students were older women, several were from minority or foreign background and showed marginal fluency in English. A lot of them

came from broken marriages, from shattered family lives and from a job they had just lost. Some others had never held a job and possessed no saleable skill. Some were such functional illiterates that they got into the program by persuading a friend to assume their identity and to fill the application form for them.

The nurse's aides, at least in a metropolitan setting, exist in a harsh social world that brutalizes their self-esteem. And then they enter the nursing home world which hardly contributes much to their self-worth either. Every aspect of the aide's task reminds them that they make up the bottom of the health care labor market. They are paid the lowest wages, they are given little discretion, they are subjected to constant supervision, and they provide the most menial repetitive, unskilled service to old people who may not even be nice to them.

Anthropologist Maria Vesperi obtained employment as a nurse's aide in a nursing home. Based on her experience she has evocatively described how a nursing home systematically alienates both residents and aides alike.[84] Whatever little sense of service, optimism and self respect the aide brings with her, soon harden into resentment. And sadly, the aide blames her disappointment and alienation on the residents, rather than on the working conditions that have dehumanized her.

We found that management in good nursing homes show great sensitivity to the aides' personal circumstances. "They come to us with a lot of kindness in their hearts," Rev. Crede of the Sunset Home in Quincy told us. "We have as much of a moral obligation to our employees as we do to our residents," is the way Jim Metzger of Restmor at Morton expressed his solicitude.

Crede and Metzger speak for the rest in our group. We saw how compassion works in these homes. Managers listen to the aides' trouble, they accommodate the schedules, they give them personal loans, they send them for counselling, to alcohol treatment programs, and to other help available in the community.

We asked the employees in each of these homes what they liked best about the management. They told us repeatedly that it was the personal

element that satisfied them most. The aides' response was consistent across the homes, and they expressed it in familiar phrases: the management is "supportive," "caring," "understanding" and "friendly;" they are "open to us," "always available," "always helpful;" they "take time to listen," they are "cooperative," and "fair."

We found that good managers protect their aides from "residents badgering them," as one of them put it. Bathing, grooming, feeding and changing underpads throughout the day are not the most rewarding jobs. Some residents make them even less so. Managers in good homes readily concede that they have their share of the crusty type. "Some folks simply do not age gracefully. Some were crabby at the age of 18, and they are soreheads now when they are 87," said one administrator knowingly.

We talked with the aides about the residents. Overwhelmingly the aides tell us they enjoy them. But they also suggest that some are "too demanding," "impatient," "ungrateful" and even "foul-mouthed." One administrator is particularly protective of the minorities. "Nursing homes are not a racial paradise," he explained. "I have to deal with the prejudices the elderly bring with them. Sometimes they are very vocal about it and harrass the aides: 'Why don't you go back to Africa?'"

Good managers appreciate how important, though unrewarding, an aide's work is. They expressed to us that esteem repeatedly and with some emotion. They are discomfited because they pay them poorly. "The unions are part of the problem," said Jackie Mason of Burgess Square who spoke sensitively of the dilemma and her efforts to deal fairly through the unions. The DuPage Convalescent Home pays a better wage than any home we know. "But we catch constant flak from the area proprietaries," says Ron Reinecke; "they accuse us of distorting the market."

You get to respect good managers the more you observe the approach of the unexceptional ones. The run-of-the-mill administrator in an average home barely disguises his contempt for "the underclass culture" of the aides, as one referred to it. He assumes that their uncouth background begets their uncaring and irresponsible attitude in the nursing home. He sees no alternative to a hard-driving supervisory style. He believes implicitly in the justice of the

marketplace and bargains hard to keep wages down to the legal minimum.

D. Creating a Motivating Environment

Good managers care about quality, respect their employees and value their contribution. They get good results because they make the workers part of the nursing home family. You give more than your work for your family, you give it your best, you give from your heart.

Critics who debate what ails American business conclude that concern with lasting values, rather than with the next quarter's results, is what Japan has cultivated and America has neglected. Industry and management schools have begun to listen to the good advice. Programs are underway to create family-like environments in corporations. One member of Harvard Business School's now famous '49 class has capsuled the prevailing wisdom: American industry would be much better off today if it had fewer of the sort of high-powered executives that Harvard turned out, and more family-run companies driven by a value system that is an extension of family values.[85]

Levi Strauss, Johnson Wax, Marriott Hotels and others are widely admired and successful family companies that are concerned with quality, their employees and the community in which they have roots. Consumers perceive their products to be of higher quality, because of their name, their pride, their integrity and their love, say the experts.[86] Johnson Wax shares profits with workers and still maintains a no-layoff policy. Apparel companies have fled abroad seeking low-cost labor, but clothier Phillips-Van Heussen maintains half of its production in the U.S., because these employees have worked for the company for generations. The 59 year old Mariott Corporation has grown to $4.24 billion sales in a year, but it still continues the same old guiding philosophy: "Take care of the employees and customers." Business Travel News ranked Mariott Hotels the best over all in the U.S. in 1985.

Building a family starts with careful selection. We learned from good managers that they prize attitude more than anything else when they recruit new hands. In some homes careful selection occurs before formal application. They maintain a liaison with area colleges that conduct internships

at the homes for nurses and aides. Management keeps a careful eye on the young interns, spots the compatible ones and woos them.

Once a recruit comes aboard, the strategy is to drench her with the in-house philosophy through prolonged orientation and in-services. Lake Bluff trains an aide with an additional whole week, even if she comes with a formal training; three solid days of class, and two on the floors. The DuPage Center maintains two full-time in-service teachers. Regular and careful supervision is indispensable in all good homes.

As we have already noted repeatedly, emotional rewards by recognition and appreciation abound whereever good management flourishes. If you are aware what an average home does, you will be amazed at the contrast, and at how good managers stroke the egos of their employees. Their employees are constantly written up in the newsletters; their photos appear on the bulletin board; employees of the week, month or year are routinely recognized, given awards and publicly toasted. You label a person a winner, and celebrate every victory, and you have created a champion who takes pride in one's achievement.

An enlightened manager trusts the workers, presumes they are responsible and deals with them like professionals, regardless of how mean their task. The opposite is what we found in two second-rate homes. Their Administrators gave little authority, choice or discretion even to their BSN nurses and MA degreed employees. They were not consulted on any matters of moment, they were assigned a daily schedule to follow and were expected to report how they followed it. Everyone of them left before the year's end.

"We are all chiefs here, hardly any Indians," is how Norwood Park's James Herbon describes his approach to management. Like other eminent administrators, he believes in delegating authority.

At Restmor in Morton, Jim Metzger has set up a Nurse's Aides Committee. The aides choose their delegates and the Director of Nursing chairs the meetings. The Committee discusses policies and procedures and makes recommendations. Twice a year all the aides meet to discuss problems, seek solutions and celebrate their victories. Restmor, like DuPage, holds exit interviews with departing aides. They want to know what went wrong.

The DuPage Convalescent Center stresses responsibility and

accountability by dividing the facility into seven units that have developed their own unique identities. Some homes in our sample have experimented with permanent or semi-permanent assignment of aides to particular units. The success has been somewhat mixed. Each home runs on its own singular chemistry that creatively blends the management style, the character of the labor pool, the resident-mix and the physical layout. Every formula does not readily lend itself to permanent aide assignment to residents; or so some administrators tell us. The reality, however, may be somewhat different. Permanent assignment is a fairly new management concept. Despite all its obvious virtues, it may not easily blend in with the established ways of an old-style, successful manager. The tendency then is to give up on it too soon.

Superior homes enjoy a satisfied work force. Yet, none have achieved a paradise on earth. They have their share of false starts, tumbles and falls. But it is your mark of superiority that you know where the problem lies and you try to plug the hole.

Even good homes suffer an occasional problem of things that disappear. Of course forgetful or confused seniors can and do misplace their dentures and point the finger at the aide. Still, an occasional perfume bottle, a silk blouse or a pair of socks does take wing. An experienced administrator knows, as one put it, that "there are only two steps from honesty to dishonesty: an unfulfilled need and an opportunity to steal." At Lake Bluff, the management gives bonuses well ahead of Christmas and holidays, the times when pilferage usually occurs. "By gosh, if you are so desperate, come and tell me; I'll buy you a silk blouse"—that is the candid approach Jim Bowden takes.

At Burgess Square, Jackie Mason found out that you always have some aides who are not enthused about bedside care. She confronted the issue head on: "When you have a problem, you put all heads together, and solve it. There is always a solution." So she created a separate category of workers, the unit aides. These are certified nurse's aides, paid on the same scale as others, but who choose not to provide person-to-person care. They collect the laundry, do the beds as well as every other chore. We found them well satisfied.

At Lake Bluff Jim Bowden found out that some aides look for the cracks in the system and to use them to advantage. They tend to float among

the area nursing homes in search of temporary gain. That crack was easily plastered over. Lake Bluff reached an agreement with other area facilities. Now all of them check on the work history of new recruits and keep the deviants at arm's length.

High-caliber managers seem to know that man does not live by bread alone; nevertheless bread remains the staple incentive in human motivation. Appendix A. V-VII detail the fringe benefits our eight nursing homes give to their workers. Employees recognize that by industry standards that theirs is a generous package. But more importantly, these benefits give them just an added proof that they work for a concerned management.

Some homes hold out specific rewards for not missing work. On a more fundamental level, they offer them security, educational advancement and mobility within their system.

Among the finest feats of a successful manager is the motivating environment he has nurtured. And he reaps his greatest reward--loyalty, pride and excellent care. At more than two of the eight facilities, employees have rejected repeated union overtures and some of its strong-arm tactics. At several of them some aides travel long distance to get to work. They stay on for years, and, from what we learned, they are indeed satisfied, are very attached and take great pride in being part of a great operation.

The staff give of their heart to the residents and to the institution. They take the residents home, bring them gifts and visit them on off days. At Norwood Park the employees contributed generously and installed a new carpet for their chapel. Last year they raised funds from their own ranks to match the generosity of the volunteer women's Service League and built a large and beautiful courtyard where they proudly wheel the residents out.

The staff pay the Little Sisters the ultimate compliment. Some of them embrace their ideal, give up the world, join their rank and become Sisters themselves.

CHAPTER 11

SUPERIOR AND INNOVATIVE CARE

"You cannot jive old folks. They have lived long and know the game. You may think they are out of it, but they see through the bluff. They know when you are concerned and if you really care." That is how one administrator of an excellent home responded when we asked how one judges good quality. "Go and ask the residents. Find out how happy they are with the care they receive. Ask their families. And you will know."

The state has begun to heed the good advice. State surveyors now increasingly inspect actual care being given, and they have begun to ask the residents about it. QUIP, Illinois' quality incentive program, rates and rewards nursing homes on six counts. Among these is resident satisfaction. While on their inspection, QUIP nurses engage the residents in a friendly interview. You will be edified by what they have found in the homes we have selected for this study. Residents speak glowingly of the care they receive; they have earned for each of these facilities a rating which far exceeds QUIP's high standards.

That is no mean accomplishment. Especially so, since the care in a nursing home and the residents' expectation differ markedly from those in a hospital. A hospital looks primarily at the disease, it subordinates the patient's feelings to the dictates of the laboratory results, it assumes a technical approach and largely ignores the patient's family. In a hospital, the medical conquest of disease is what counts above everything else.

Not so in a nursing home. Residents are generally free of acute illness. Their afflictions are chronic. And chronic problems call for extended management, they do not yield to a quick technological cure. Improvement of function, independence, meaningful relationships and quality of life constitute the sum and substance of nursing home care.

Superior homes provide such care in a superior manner. They are hampered, as are all nursing homes, by a medical bias that distorts the

priorities in long-term care. Yet, good homes hold the right course; they single-mindedly gear their operations to meet the needs of their residents, physical and medical needs for sure, but above all their emotional, spiritual and social needs.

A. Nursing Home Care and the Medical Bias

Talk about health problems and you are likely to conjure up in people's minds the image of physicians and hospitals, not of nurses and nursing homes. There you have an example of the prevailing medical bias in matters of health. The medical model dominates the health care system. It is a model that focuses on pathology; its forte is heroic, technological intervention; its practitioners are specialists; its care is fragmented. This is the model that reigns supreme in the U.S. and draws to itself much of the glamor, rewards and the health care dollar.

Long-term care does of course include the medical element, but it encompasses much more. Its primary thrust is rehabilitation and management of chronic disability. Psychological and social services are more central to it than are medical services. Therefore, would you not expect that the model would prevail in nursing home care?

But it does not. A medical bias dominates the care in a nursing home. The physician, who is conspicuous by his absence, still determines the standards, form and pace of nursing home care. No one enters a nursing home without a physician's order, and no one stays on without an attending physician. No care plans—medication, physical therapy, use of catheters or restraints—none of these and other care plans can be arrived at or changed without physician's orders. Medicare insists on labelling a resident a "patient," and will reimburse only for a post-hospital stay.

Medical dominance has turned the term "nursing home" into a misnomer. A nursing home neither allows nursing care the primacy it deserves, nor is it a real home for the residents. Nursing homes have been reduced to mini-hospitals.[87] The medical dimension has been overblown. Rehabilitation and psychosocial services do not hold the central role, they have become

adjuncts to medical services

Despite his dominance, the physician scarcely shows up in a nursing home. Only 8.3 percent of all physicians even visit nursing homes. If you are a primary care physician you spend less than 90 minutes there in an entire month, and if a specialist, less than 30 minutes.[88] In most cases the resident-physician contact adds up to less than 30 seconds a day.[89]

So you now have the right formula for the common misfortune that befalls many a nursing home: the physician serves as the supervisor for all medical services and as the gatekeeper for the rest, but in fact he is hardly involved in the day-to-day care. The nurse therefore becomes the monitor of care and the medium for physician contact. But she flirts with danger when the physician refuses to return the call, likes to prescribe on the phone, will make few follow-up visits, and will often visit only after the crisis has been resolved.[90]

The mismatch between resident need and the medical slant creates other problems as well. Take misdiagnosis. Half of all residents may be given a diagnosis that does not reflect their real problem. Nine out of ten nursing home diagnoses, some investigators have discovered, are medical, when in fact only about a third of the residents have medical problems. Psychological and social needs are routinely missed.[91]

Iatrogenic effects of institutionalization illustrate another failure of the medical set up. A resident enters a nursing home, as a rule, with problems of the heart, stroke and arthritis. The pattern of common post-admission diagnoses, however, tells another story: urinary tract infections, eye and ear infections and bedsores.[38]

Next, consider the failure on the medication scene, which comes directly under physician responsibility. One federal survey of skilled care facilities unearthed a sad tale.[92] Only 0.1 percent of the residents were free of prescribed medications. The average resident was on 6.1 prescriptions; 15 percent were on ten or more! Half of all nursing home residents were on tranquilizers or sedatives, and often on a "p.r.n.," or "as needed" basis. Other investigators have concluded that nursing home drug regimens are poorly designed, poorly monitored, wasteful and even dangerous.[91]

Finally, one wonders how much the institutionalized elderly may be subjected to unnecessary tests and examinations in the name of good medical care. Even in a highly reputable institution like Boston's Hebrew Rehabilitation Center for the Aged you find that routine laboratory screening tests have added nothing to the care.[93] They are done as a matter of convention. Nursing home laboratory tests, routine annual histories and physicals have also been found to have little usefulness.[94-96] The problem lies in the inapplicability of these medical rituals to the real needs of the nursing home residents. Established medical routines are notoriously deficient in geriatric concepts and care.

In sum, all these deficits add up to yet another formidable impediment to quality: long-term care is excessively medicalized and rigidly controlled, in absentia, by the physician. Viewed in this context, the success of the good nursing homes appears ever so striking. These homes override the medical bias, and they never lose sight of what long-term care is all about.

B. Overriding the Medical Bias

Excellent homes follow a simple strategy in beating the problem of overmedicalization. They are very careful in whom they select as their physicians. Every home in our sample sang praises of their medical director. From what we learned, these homes are blessed with exceptional physicians, devoted and generous in their time and in their love. None of them are trained geriatricians, but all have that caring touch and show an affinity with the elderly. But most of all, they subscribe to the caring phiolsophy of the home in which they serve, and to its commitment to the frail elderly; they understand what long-term care really is.

The Norwood Park Home is as good an example as any other. Norwood Park manages to have all the residents attended by a single medical director, Thomas Pawlowski, a young physician with an uncommon rapport with the elderly. He spends two half days a week at the home, and remains on call 24 hours every day.

The nurses love Dr. Pawlowski. They tell us how well he relates to the residents and understands their needs. Upon admission, he succeeds in

to nursing home care—the social model, the team approach, case management, the functional method, among others.[112,113] Each of these, as you may expect, optimizes one feature and sacrifices another. Hardly any has been seriously tested.

Primary care nursing is a more specific approach to care that has been promoted by advocates of quality. If you choose this route, you want a nurse's aide to provide total care to the residents assigned to her. If you do not, as in the old way, different aides share the responsibility for each resident and they retated through the facility.

Permanent assignment will improve resident care, the advocates argue, because it clearly delineates tasks and accountability, it gives a sense of permanence to the resident, it individualizes attention and makes it consistent. The aide can readily identify her contribution and be pleased at completing an entire task, a satisfaction denied her in a fractional, assembly-line type of work assignment.

These claims have not even been completely validated in the hospital setting.[114,115] And of course they have not been seriously evaluated in nursng homes. Most of the homes in our sample, however, have tried assigning aides semi-permanently to resident units. They told us that their experiment has been successful, although we did not detect any euphoria over the outcome. In one home which gave the model its best shot, the experiment flopped. But their care remains unexcelled.

Directors of Nursing pointed out to us the problems of a primary care model, the same ones which you will read in the literature.[116,117] Some aides are unwilling to accept total responsibility for a resident. Some others become too possessive of their wards; in turn the residents get so attached to them that they will not cooperate when a replacement is made. Still other aides resent the unequal workload when assigned to too heavy care residents. In some cases "familiarilty has bred benign neglect," one Director confided to us.

"We tried our hand at assigning aides permanently to a unit. It didn't work, so we are back to our proven ways. You can see that our care is excellent. Wouldn't you say there are different paths to paradise?" That was an Administrator of a six-star QUIP home explaining to us the failure of his

primary care experiment. The problem, we suspect, lies not in the model itself. Even good managers hate to depart from the beaten path and may be somewhat blinded by their old proven ways. Assigning aides permanently to a unit means that you not only consider the residents' needs, but also carefully evaluate the desires and skills of the aides themselves. The failure of the primary care model often signifies an otherwise good management getting calcified at the edges.

When you organize to achieve good care, you pay attention to care plans. Good care plans are individualized to meet the resident's needs and to achieve specific goals. They assure consistency and continuity, and in general serve such good purpose that Medicare and the state mandate them, and the American Nurses Association advocate them as a basic standard.[118]

QUIP, the IDPA's incentive program, evaluates how effectively nursing homes manage resident care. It looks for any intensive intervention programs a nursing home may pursue. QUIP nurses say that many nursing homes perform respectably on this count.

QUIP also determines how carefully nursing homes derive their care plans, how they set goals for residents and how they achieve them. On this front the news is spotty. QUIP surveyors tell us that many nursing homes around the state that do give good care still fall short on care plans. Half the homes in our sample missed the perfect six-star rating in the first round in 1985, because they did not measure up on care plans. They rallied and hit the jackpot all right in the second round.

We asked these star performers to rate QUIP in return. They all spoke in one voice. QUIP has probably done wonders for the mediocre homes, they told us. As for themselves, they are unsure. QUIP's added attention to care plans may not have directly improved the care they give. But QUIP has brought them more than added dollars. Now they go about their care plans more consciously and systematically. More importantly, their interdisciplinary dialogue has improved, and that has resulted in more carefully drawn care plans and better charting of the care they give.

But the report card is not all applause. Our eminent caregivers wish that QUIP would find ways to reduce their paperwork. Some also wonder

cutting the resident's medication in half. He never lags behind in his charting. He writes voluminous notes, and happily, say the nurses, he writes a very legible hand.

Dr. Pawlowski stands out from the average physician in another regard. He respects the nurses at Norwood Park and approaches them as professionals. He acknowledges what another physician will rarely accept. It is the nurses and aides that really care for the resident. They are tuned in to the resident's idiosyncracies, needs and reactions. They pick up subtle changes in condition, mood or spirit, all vital clues needed to design a therapeutic regimen. So Dr. Pawlowski listens to what the nurses and aides have to tell him. He reviews cases with them, accepts their suggestions and makes appropriate changes.

The other homes that we studied are not unlike Norwood Park. One or two of the physicians in each home cover a majority of the residents. They concur with the management's goal of a humane, nonmedicalized approach to the care of the elderly. They are ever present or on call; they abjure the use of restraints and catheters. They will not overmedicate, overhospitalize or overtechnologize death. They are true geriatricians, not necessarily in training, but certainly in practice and in attitude.

Admittedly these M.D.s are rare, though refreshing, examples of their species. Good nursing homes go to some effort to discover and to cultivate these enlightened souls. This quest, however, can take them through a rugged terrain. Physicians do not naturally gravitate towards chronic care. Rather, they avoid it when they can.

Take Norwood Park again. Dr. Pawlowski has, time and again, arranged for physicians doing residency at the neighboring Ravenswood hospital to visit Norwood Park and to learn about geriatric care. The nursing home is all geared up for their visit, the nurses are all primed and the residents waiting. Time and again nobody shows up, and only rarely will one call and give an excuse. The Director of Nursing has heard them all; she can tell you what the next excuse is going to be.

You do not have to be a keen observer to note that the physician's disaffection for nursing home care is near universal. We learned that at one

teaching hospital efforts to institute a nursing home residency have floundered in an ocean of apathy. You would have gotten that point if you attended their party at the medical school last May. The students staged a skit in which they awarded fictitious residency placements in order to reflect the quirks and values of medical culture. The mushhead in the class got his desert, an assignment to the nursing home!

Theodore Schwartz, a physician, displays insufferable naivete when he prescribes a formula "for fun and profit," and proceeds to sketch the scenario of "how to install a first-rate doctor in a third-rate nursing home."[97] Third-rate nursing homes abhor the prying, quality-minded physician. And the physician for sure pays back the compliment; he finds the nursing home depressing. Chronic care is not what he is trained for, it holds no glamor, it hardly yeilds to technical intervention, it has no quick and satisfying cure, and he does not make money visiting patients in a nursing home.

The lofty concept of "the teaching nursing home," according to which health professionals would receive part of their training at the nursing home, still remains too lofty to be practicable on a wide scale.[98] Some successful experiments hold important lessons. But the clash between the university and the nursing home culture remains unresolved.[99]

But where there is a commitment, there is a way. Excellent nursing homes have all sought out the rare physician who loves the elderly and dignifies their life with his caring touch. And they all have found one.

C. Organization of Good Care

The American health care system may have failed the mobile society. Americans are on the move, but their health data does not travel with them. The medical data does not accumulate and it is not organized in a way to ensure continuity of care.

Medical information also falls between the cracks when a senior enters a nursing home, one's transfer form notwithstanding. The resident's family physician may be reluctant to visit the nursing home and may hand over care to another physician or may visit rarely for a good medical biography to

build up. The DRG-based prospective payment system has prompted hasty discharges making continuity of care even the more problematic.

The nursing homes we studied have established firm liaisons with their feeder hospitals. A few pay special attention to discharge planning. The Master's prepared social worker at Restmor in Morton makes constant rounds of its hospitals, provides in-services and ensures continuity. At the Norwood Park Home the medical director keeps careful tab on the resident's medical biography. Still, by and large, nursing homes do not demand and do not receive comprehensive medcial summaries on their residents. This lapse results in unnecessary tests and dangerous drug regimens.

Medical care, even in good homes, is flawed for another reason. It lacks sound geriatric content and pertinent geriatric information. The established order and a deficient geriatric training may be to blame for this failing, rather than a lack of will on the part of the nursing home.

Thus, physicians lacking in geriatric expertise may be unaware of the dangers of polypharmacy among the seniors. Their annual check ups fall short on matters crucial to their geriatric clients: a thorough evaluation of the nervous and musculoskeletal system; the functioning of the senses, the bladder and the bowel; the needs of nutrition, of the mind and of one's emotions. In short, medical routines do not deal meaningfully with issues of central concern to the frail elders, the management of chronic ailments and the activities of their daily living.[100]

There are recent innovations that have been developed to redress some of these traditional deficiencies. We were disheartened, however, that the most promising of these, the geriatric nurse practitioner (GNP), was not much in evidence even in the good homes we visited. GNPs are registered nurses specifically schooled and certified in geriatric practice. As primary care providers they blend clinical skill with medical management; they assess, monitor and manage uncomplicated problems of the aged. They give proactive, total care: education, screening and coordination. In collaboration with a physician, they establish, monitor and adjust protocols.

Physician-GNP collaboration has brought a level of professionalism into nursing home care barely heard of before.[101-104] It improves coordination

and quality, reduces hospitalization, minimizes liability risk, contains costs and bridges the traditional hiatus that has isolated long-term care.

Organized medicine, the legal code and physician prejudice have all hampered the growth of the GNP.[20] But the tide has turned. HMOs and other competitive medical plans have discovered the GNP's potential. An Institute of Medicine study has strongly endorsed the GNP concept.[105] Both Washington and state capitals are promoting the GNP. It behooves nursing homes to seize the opportunity and to become allies in redressing the weaknesses of the past.

We were heartened, however, on a different front. The better homes seemed to us to have fewer infections, although we conducted no systematic comparisons. Compare nursing homes to hospitals, and you will note that prevalence of infections in nursing homes is similar to the rates of nosocomial infections involving urinary and lower respiratory tracts. But nursing homes come off much worse in matters of skin infections, conjunctivitis and diarrhea.[106-109]

The problem with nursing homes is that they attempt to control infection the way a hospital does.[110] In the process they do not fully take account of the peculiar reality of nursing home life: advanced age, underlying disease, incontinence, indwelling catheters, medications that increase susceptibility, an antibiotic-resistant environment—all factors that contribute to infections.[111]

We did not find that the better homes showed any greater appreciation of these problems. But their success in holding down infection seems to be yet another happy fallout of their superior management. Better managers create an environment conducive to infection control. They maintain excellent staffing ratios and hire more professionals; they lose fewer staff and enjoy greater stability; they compensate for sick leave and insist on resident and staff immunization. These are precisely the conditions, researchers tell us, that cut down on nursing home infections.[111]

If hell is paved with good intentions, as the old adage assures us it is, the reason is that a caring heart and a good intention do not necessarily produce good results. Institutional care has to be specifically organized to achieve high quality. Experts on organization have proposed various approaches

whether the restorative nursing model should not be tempered with custodial and maintenance goals.

Every good home organizes its care in a way that suits its character. Each adds its own twist. Northwest Home, to give one example, insists on a half-hour overlap of shifts for all staff, including aides. The incoming aides make rounds with those about to depart, and receive detailed reports on the residents they will take charge of.

D. The Psychosocial Approach to Care

A medical culture usually permeates a nursing home and the care it provides. The preeminent homes, we have already shown, surmount that bias and its ill effects. With admirable skill they organize their services to meet the needs of the residents, not merely their medical needs, but also their mental, emotional and social needs.

In an earlier chapter we alluded to the importance of the residents' sense of autonomy and control and how well the first-rate homes enhance it. The QUIP nurses look at resident autonomy in yet another way. They size up the physical environment, the adaptive equipment that increases independence, the audio-visual accoutrements that aid communication and the room decor that adds the personal touch. They inquire about resident participation and choice in activities and in development of plans; they are interested in the quality of resident involvement.

As you may expect, the homes we studied, come out in flying colors in the way they develop a psychosocial ambiance that promotes resident morale and well-being. QUIP nurses have found that residents in these homes are highly satisfied, their morale and spirit run high. If you can design an appropriate study, you would probably find, as the literature assures you will, that these residents are also in better health.

Researchers are clear on this point. The seniors come to the nursing home after progressively losing their symbols of status and control. If a nursing home offers them choices and makes them feel they are in control, their morale soars, they adjust better and they are more satisfied.[119] In a reverse

case, a learned helplessness sets in along with passive behavior and depression.[120,121] When one feels isolated premature death may result. No wonder that when you ask residents how quality can be improved, they clearly say their top priority is to be able to make their own choices.[82]

You make the seniors feel they are in control not necessarily through expensive gadgetry and elaborate programs. You boost that sense or destroy it by simple actions and attitudes—the way you respond to their little requests, for example. Haim Perlstein of the Northwest Home illustrates this point tellingly. "I never fail to follow up on a resident's request, big or small," he says. "For a ninety-two-year-old disabled lady it is of great importance that her husband's portrait on the wall, which somebody has knocked off balance, be straightened. She may have mentioned it to five different people. They were all busy, and then they forgot. She will sit there helpless and frustrated."

We have noticed such careless attitude in too many homes. If you respond quickly to a resident's request and do it cheerfully, you may notice the surprise in the person's face. Residents are not used to such prompt courtesy, and they will thank you profusely. If their response seems out of proportion to your simple courtesy, it is meant to reveal to you the sense of helplessness in their daily life.

Just as everyday words, gestures and actions can uplift or alienate, so can they confer dignity or destroy it, make a resident feel secure or threatened. Much of nursing home behavior that is labelled senile, uncooperative and hostile, Vesperi argues persuasively, is behavior which the institution has provoked. When you are made to feel helpless and dependent, and the nursing home allows no dignified avenue of protest, what is the most logical human behavior?[84]

Incontinence and refusal to eat are often diagnosed as inevitable problems of senility. They may in fact be symbolic protests of residents who suffer from isolation, depersonalization and withdrawal. Maria Vesperi, an anthropologist, viewed nursing home life from a worm's point of view after obtaining employment as a nurse's aide in a nursing home. She shows why the "senile behavior" of the resident seems pitiable to an outsider, and why sedation, physical restraint and frustration of the aide seem reasonable

behavior. The visitor however is viewing the tail end of a harrowing episode, and is not privy to the not so subtle ways in which the nursing home has stripped the resident of all personhood.

Good nursing homes succeed in breaking this hopeless cycle of depersonalization, protest and restraint, because they truly care. So they adopt a style of management and adopt a mode of care that meets the personal, emotional and spiritual needs of the residents. Religion plays a part in it, and so do the volunteers, the family and the numerous activities, and they all add up. They all mean a sense of security, belongingness, dignity and autonomy to the resident.

Commitment and devotion are essential ingredients, but the striking feature of good managers is that they are imaginative and innovative. They always seem to find solutions to problems of daily living in a nursing home.

Consider the problem of integrating confused residents into your daily routine. Norwood Park is loath to confine their confused residents to one unit. They have succeeded in distributing them throughout the home. Does this arrangement not cause problems? "Of course it does," Jim Herbon will tell you. "But we take pride in us being a family. And a family accepts the burden when some members are less than self-sufficient, when they wander. We look after one another."

Other homes have installed alarm doors, magnetically sealed door ways, a half-door arrangement that confines a confused and wandering resident to a room or a unit, or a fenced-in yard that keeps such residents free within a safe environment.

Restmor in Morton won an award at the 1986 Governor's Long-Term Care Conference for their Special Care Activity Program for Alzheimer Residents. Remarkably, this innovation emerged out of staff initiative. "The staff were frustrated about dealing with some of our Alzheimer's residents," explained Jim Metzger. "So I called them together to work out a solution. Almost overnight we had a brand new approach."

Restmor's Alzheimer's program runs two and a half hours every morning and one and a half hours every late afternoon. It includes 11 to 16 residents who do not function well in large groups or higher level activities.

The aides vary the activities to suit different abilities. The residents fold laundry, wind yarn, make Christmas decorations, visit the nursery school children, do simple math, bake, toss ball and create their own games.

The program started less than a year ago, but everyone has noticed a remarkable change. Even the passive and resistant participants are now actively involved and look forward to it. Agitated behavior has declined, cooperation has increased, residents seem calmer, happier, and less troublesome to others. Restraints have been removed from several residents, even the psychotherapeutic medication has been reduced. All these benefits from a program that was initiated by the staff, was run exclusively by aides, and costs a bare $1,300 a year. It deserved the Governor's award. Its success prompted full time staffing and the expanded program now runs eight hours a day.

Why do first-rate homes seem to have all these innovative appraoches? In the first place they have smart managers who listen to the staff. The staff are the frontline caregivers. They are tuned in to the needs of the residents. They will show you imaginative ways to lick a problem, if only you will listen to them. Second, smart managers keep their antennae well tuned to the innovations in the industry. They visit places, attend conferences, read the journals and generally keep abreast of the state-of-the-art developments in the industry.

Lake Bluff provides one illustration. They have added personal computers into rehabilitation therapy for Alzheimer's and stroke victims. The computer program has eight diagnostic and rehabilitation components. They aid in visual field deficits, eye-hand coordination, selective attention, memory, attention span, problem solving and much more.

The outcome has been outstanding. You will have a hard time now pulling a ninety-year-old lady away from the terminal. In the traditional occupational therapy you can detect resentment when you ask an older person to do simple, repetitive things that their grandchildren did. The computer, however, individualizes the therapy, provides variety and keeps raising the level of the challenge. The staff has been able to diagnose more accurately, they have observed significant progress in visual memory, visual scanning,

abstraction and word generation.

Residents are more cooperative in their therapy. One 88 year old resident said it best: "I've seen the pyramids, lunched with the Queen of England, and have been all over the world. But this is the first time I have ever used a computer." She loves it and looks forward to it. And so do many others.

For another illustration you must return to Restmor. Jim Metzger is constantly scanning the frontiers for new ideas. He has installed a computer program, which is probably the most advanced in the industry. The innovation is not so striking in regard to accounting, billing and data collection, though it is the best you will see anywhere. But it is specially admirable the way it helps the care process. A clerk can go to to any of the several terminals in the home, press a few buttons and instantly recall any relevant resident information on the screen--physical and medical, or related to drugs, therapy, family, hospital, etc. The computer also prints out in simple readable form the weekly care plan assignments for nurses and the aides. It also prepares a monthly, easy-to-follow, complete medication administration record sheet per resident.

Jim Metzger, a pharmacist by training, also instituted a drug holiday program at Restmor. The drug holiday concept originated in a psychiatric setting in the treatment of schizophrenic patients.[122] In simple terms, it means the withholding of medications for one or more days, usually on Saturdays and Sundays as at Restmor. It is especially suited to the geriatric resident. The prevailing wisdom merely distinguishes children's dosage from adult dosage. Drug treatment also needs to consider age-related changes in the elderly: renal clearance, hepatic biotransformation, protein binding, drug distribution and sensitivity to drugs especially in polypharmacy.

The drug holiday program at Restmor called for careful preparation: a thorough evauation of the resident, in-servicing the staff, consultation with residents and family, cooperation with the physician and collecting accurate information. These efforts have paid off. There has been no noticeable adverse effects on residents. Drug regimens for several residents have been reevaluated and reduced. In some cases disorientation and sleep medication have decreased. Nurses have been freed to give more bedside care.

In sum, you find superior care in superior nursing homes. That accomplishment must be applauded because it occurs despite the prevailing acute-care bias that medicalizes nursing home culture. Good nursing homes consider themselves the givers of chronic care which calls for a psychosocial orientation. They organize their services and marshall all their resources to that end. They are committed, imaginative and innovative. By all measures their residents are a happy lot. And no wonder. They get the best care anyone can expect.

CONCLUSION

A pall hangs over our nursing homes. Nobody wishes to be admitted to one. Many people will tell you they will never go into a nursing home under any circumstances.

This sullied image of nursing homes may well be deserved, but it is also unfair. Yes, the first thing you notice in an average home is its mediocrity. The run-of-the-mill home is indeed a far cry from a quality facility. But you should also note that there are real gems out there, of unsurpassing quality, nursing homes which house our elderly and care for them with devotion, enthusiasm and competence.

We visited some of these champions of the elderly. We were both overwhelmed and moved. We were also grieved, because Americans know so little about these star performers. We hardly recognize them publicly, scarcely appreciate their achievement and rarely applaud their success.

At the same time, we were intrigued. In quality and service these nursing homes have surely moved way ahead of the crowd. But they are exceptional, we discovered, only in their distinguished service and care, not in any unique talent or exceptional resource they possess.

This study was only partly meant to celebrate the success of these homes. We were intent, rather, on uncovering the secret behind their success. What makes them soar and hold the high ground? What are the guideposts that help them steer clear of the pitfalls that confound many of their lesser brethren? What strategy do they follow to surmount the common problems that afflict the industry?

There is many a nursing home in Illinois deserving of the gold medal. Their care is excellent by whatever yardstick you may use. We selected eight eminent examples and studied them intensively. We could have selected many others. But our purpose was mainly to chart the common strategies that successful nursing homes pursue. So we settled on a small representative group which suited that purpose.

We have painted with a broad brush a picture of superior

performance in these homes. We have sketched a portrait of excellence along six different dimensions. These homes differ widely among themselves, but the pursuit of quality has taken them along common and familiar routes. We have tracked these six pathways to excellence and identified the landmarks and the potholes along the course.

Studying these exemplars of quality was an uplifting experience. It also let us to some firm conclusions. To begin with, nursing homes in the United States do indeed exist in a harsh environment. They enjoy little public respect and support, they are heavily regulated, and an artificial barrier segregates them from acute care and deprives them of equal status, rewards and reimbursement.

Admittedly, the industry itself is not blameless for this sorry mess. Entrenched interests have made real reform difficult to attain. Regulation has limped along and has remained spotty. Bureaucratic controls have sometimes reduced quality to an almost meaningless shell.

These external constraints are indeed real and formidable; we have sketched them in some detail in the first part of this narrative. The more you recognize their compelling force, however, the more you admire the stars in the industry who have overcome the odds. They face the same roadblocks and share the same milieu as the rest of the homes. Yet, they have surmounted the obstacles and outperformed the crowd. And in so doing they tell us something important: you cannot merely blame the environment and bemoan the constraints it puts on achieving quality. You have also to recognize the enemy within, the malaise that afflicts the nursing homes' management, that saps their commitment and frustrates their own efforts at attaining a high level of care.

Such a realization comes with some force when you note that excellent caregivers are not by any means a privileged group. Consider the homes we studied. They well reflect the diverse character of the nursing homes in Illinois—in resources, affiliation, tradition and the profit motive. Half of them did not even qualify for an elite status just a while ago when they changed hands. At present however, they are all the envy of the industry. The state and federal agencies point to them as exemplars of quality. The Illinois

Department of Public Aid has honored them with six-star QUIP awards. The community holds them in high esteem and flatters them with a long waiting list.

Success has not come to them because of any privileged circumstance. Nor is it given to them on high. These homes bear a simple but eloquent witness that where there is a commitment there is a way to achieve quality. Good care is within reach of any nursing home, whatever the external pressures or limitations.

The journey towards excellence begins with a commitment to quality. As we have shown, commitment goes hand-in-hand with a distinct philosophy which is the mark of every first-rate home. These homes then put together a cohesive management team which embodies that commitment, and single-mindedly translates it into the daily routine of the nursing home life.

We made a heartening discovery. A committed and effective nursing home management is not built on genius. It follows no mystical strategies. The best nursing home managers, we learned, possess a coherent philosophy, a clear sense of direction, an admirable set of priorities, plenty of commonsense and loads of TLC. They love the elderly, they respect their staff, they always look for innovative ways, and they doggedly turn their commitment into practical ways of serving the residents. None of this is the stuff of genius. Effective leadership is often of the simple garden-variety.

Quality, we also discovered, is an all-hands operation. It is not mere technique. No cookbook approach will lead to high level nursing home care. Excellence is a commitment the management lives by and exudes in its daily approach to the residents, to their family and to the staff. It is in the ambiance, it permeates the organization, it colors its operations, it affects the attitude and behavior of the staff. If the nursing home operator lacks commitment, no amount of posturing, incentives and well-minded management techniques can raise the care above mediocrity.

Finally, we discovered that quality is good business. It pays to be committed. It pays to provide excellent care. Good homes face no citations or penalties for poor care. Their residents, families and staff do not get on the hot line and bring down a barrage of inspectors. They do not suffer from a

costly staff turnover. Their care plans and programs add up to better reimbursement rates.

First-rate homes invariably attract a more affluent market and enjoy the luxury of waiting lists. Their reputation draws volunteers into the homes, who in turn improve care and supplement scarce resources. Excellent homes enjoy the community's munificence by way of donations, legacies and other supports.

Aiming at high quality makes good dollar sense, it may as well bring psychological and professional rewards. Unfortunately, however, the industry has traditionally been skewed towards other incentives. Many operators have entered the market to reap profit through real estate manipulations. Any dollar loss they suffer because of a lack of commitment and shoddy management practices is a small price they pay for the profits that accrue to them from other aspects of the business.

Regulation controls the supply of beds and thus guarantees even the inferior not-for-profit homes an assured occupancy. Therefore the unmotivated and the unimaginative managers run an operation that barely keeps its head above water; they rely on guaranteed revenues rather than suffer the demands of devotion and good management.

So, this study celebrates eight preeminent nursing homes in Illinois. We think they deserve the accolade because they are inspiring examples of quality and devoted care to our elderly. And more. They also illuminate and affirm these simple truths about nursing homes.

- A nursing home can achieve a high level of care if only it pursues six common and commonsensical strategies: developing a clear philosophy; maintaining a sensible management style; making the institution resemble a home; remaining open to the community; winning over the staff; and organizing towards good care.

- Nursing homes do in fact face a rugged challenge: the public gives them scant respect; the community offers them little

support; and the state regulates them closely.

- This external pressure notwithstanding, the worst enemy of quality lies within the nursing home. Most homes either fall short on a commitment to good care or they do not measure up on effective management.

- Good quality lies within the reach of anyone who wants it. It is not the product of genius or esoteric techniques. It results from devoted care and good management—not very uncommon human attributes. However, you will not find them in a nursing home where the commitment is lacking.

- Quality pays. Good service makes good dollar sense. It also refurbishes one's image, enhances morale, relieves anxiety and brings professional rewards. Good quality is simply good fun.

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A. I. RESIDENT PROFILE IN THE EIGHT NURSING HOMES: AUGUST 1986

	Total Beds	Medicare certified Beds	Skilled Care		Intermediate care		Sheltered care		Medicaid residents	
			Beds	Private rate per day	Beds	Private rate per day	Beds	Private rate per day	Occupancy	Per day rate
Apostolic Christian Restmor	146	18	37%	$49.00	45%	$42.50	18%	$26.00	15%	$35.40
Burgess Square Healthcare Centre	210	15	51%	$65.00	49%	$60.00	0%	0.00	69%	$38.44
DuPage Convalescent Center	408	16	35%	$65.00	65%	$60.00	0%	0.00	78%	$42.35
Lake Bluff Health Care Centre	231	15	17%	$80.00	83%	$55.00+	0%	0.00	50%	$42.20
Northwest Home for the Aged	160	0	59%	$60.00	41%	$60.00	0%	0.00	63%	$46.00
Norwood Park Home	271	0	0%	0.00	48%	$56.60	52%	$30.00+	24%	$40.17
St. Joseph's Home for the Elderly	137	0	36%	$50.00	25%	$43.30	39%	$15.50	63%	$40.13
Sunset United Methodist Home	248	0	0%	0.00	48%	$45.00	52%	$25.48	26%	$35.47

+ Indicates that higher priced private rooms are available.

A. II. RESIDENT - STAFF RATIOS FOR SKILLED AND INTERMEDIATE CARE UNITS IN THE EIGHT NURSING HOMES: AUGUST 1986

Shifts:	7 a.m. to 3 p.m.		3 p.m. to 11 p.m.		11 p.m. to 7 a.m.	
	nurses	aides	nurses	aides	nurses	aides
Apostolic Christian Restmor	35.0:1	6.1:1	47.0:1	12.7:1	71.0:1	29.0:1
Burgess Square Healthcare Centre	32.0:1	8.0:1	60.0:1	14.0:1	70.0:1	30.0:1
DuPage Convalescent Centre	26.0:1	10.9:1	45.0:1	14.9:1	67.0:1	22.0:1
Lake Bluff Health Care Centre	26.0:1	10.5:1	35.0:1	12.0:1	45.0:1	18.0:1
Northwest Home for the Aged	22.0:1	7.0:1	38.0:1	11.0:1	50.0:1	15.0:1
Norwood Park Home	19.0:1	6.2:1	44.0:1	9.4:1	44.0:1	15.0:1
St. Joseph's Home for the Elderly	28.0:1	6.4:1	28.0:1	14.0:1	42.0:1	16.0:1
Sunset Methodist Home	20.0:1	8:1	17.0:1	10.0:1	30.0:1	11.0:1
Average	26.0:1	7.9:1	39.3:1	12.3:1	52.3:1	19.5:1

A. III. STARTING HOURLY WAGES AT THE EIGHT NURSING HOMES

	Certified Nurse's Aides	Licensed Practical Nurses	Registered Nurses
Apostolic Christian Restmor	$4.00+	$6.25+	$7.25+
Burgess Square Healthcare Centre	$3.65	$7.50	$8.50
DuPage Convalescent Center	$5.32	$6.81	$8.72
Lake Bluff Health Care Centre	$4.00+	$7.50+	$8.75+
Northwest Home for the Aged	$4.00	$8.00+	$9.00
Norwood Park Home	$4.25	$7.00+	$8.00+
St. Joseph's Home for the Elderly	$4.50+	$6.00+	$7.00+
Sunset Methodist Home	$3.45	$5.30	$7.50

+ Indicates higher wages available depending on previous experience, shift or length of employment.

A. IV. STAFF PROFILE IN THE EIGHT NURSING HOMES: YEAR ENDING AUGUST, 1986

	Average Years of Service Among Department Heads	Annual Turnover for RNs and LPNs	Annual Turnover for Nurse's Aides	Unionized Work Force
Apostolic Christian Restmor	5	4.0%	10.0%	No
Burgess Square Healthcare Centre	6	20.0%	25.0%	Yes
DuPage Convalescent Center	10	10.0%	31.5%	No
Lake Bluff Health Care Centre	5	1.0%	10.0%	No
Northwest Home for the Aged	7	0.0%	10.0%	Yes
Norwood Park Home	5	10.0%	20.0%	No
St. Joseph's Home for the Elderly	5	0.0%	35.8% *	No
Sunset Methodist Home	5	66.0% *	48.0% *	No

* analysis in Section III, Chapter 10.

A. V. NURSE'S AIDE EMPLOYEE BENEFITS IN THE EIGHT NURSING HOMES: A

	Vacation Days After 1 Year	Sick Days	Paid Holidays
Apostolic Christian Restmor	4 weeks per year to be used for any reason		
Burgess Square Healthcare Centre	5	6	8
DuPage Convelescent Centre	10	6	13
Lake Bluff Health Care Centre	10	6	7
Northwest Home for the Aged	5	6	6
Norwood Park Home	10	12	7
St. Joseph's Home for the Elderly	10	12	8
Sunset Methodist Home	5	5	7

A. VI. NURSE'S AIDE EMPLOYEE BENEFITS IN THE EIGHT NURSING HOMES: B

	Wage Differential For Shift	Free Meals	Paid Continuing Education	Savings Bond Option	Credit Union	Pension Plan
Apostolic Christian Restmor	Yes	No	Yes	No	Yes	Yes
Burgess Square Health Care Centre	Yes	No	Yes	No	No	No
DuPage Convalescent Center	No	No	Yes	Yes	Yes	Yes
Lake Bluff Health Care Centre	No	Yes	Yes	No	No	No
Northwest Home for the Aged	No	Yes	No	No	No	No
Norwood Park Home	Yes	Yes	Yes	No	Yes	Yes
St. Joseph's Home for the Elderly	Yes	Yes	Yes	No	No	No
Sunset Methodist Home	No	No	Yes	No	Yes	Yes

A. VII: NURSE'S AIDE EMPLOYEE BENEFITS IN THE EIGHT NURSING HOMES: C INCENTIVES AND BONUSES

Apostolic Christian Restmor	Unused off days paid every month
Burgess Square Health Care Centre	1. Unused sick days paid as Christmas bonus. 2. Additional 10¢ per hour paid every pay period for no sick days or tardiness.
DuPage Convalescent Center	None
Lake Bluff Health Care Centre	Unused sick days paid on December 15.
Northwest Home for the Aged	$100 paid every 12 weeks for perfect attendence and no tardiness.
Norwood Park Home	1. $200 given as savings bonds for 1 year perfect attendence. 2. $100 given as savings bonds for 1 to 6 days absence a year.
St. Joseph's Home for the Elderly	None
Sunset Methodist Home	1. Unused sick days paid or added to retirement fund for long-term employees. 2. Vacation days accrue faster for long-term emplyees.

APPENDIX B

B. I. Survey Data from the Eight Nursing Homes.

During the course of this study, the staff at each of the eight homes were interviewed. In addition, the nursing staff were requested to respond anonymously to a questionnaire that included both structured and open-ended questions. Part of the analysis has been presented in the main part of this report. This Appendix offers some of the statistical details.

B. II. RESPONDENT PROFILE FROM THE EIGHT NURSING HOMES

	Total respondents	Race				Status					Shift			Average school years of aides	Average years employment here
		White	Black	Hispanic	Other	RNs BSNs	RNs Non-BSNs	LPNs	CNAs	Non-CNAs	7am to 3pm	3pm to 11pm	11pm to 7am		
Apostolic Christian Restmor	34	100%	0%	0%	0%	3%	9%	16%	69%	3%	26%	49%	25%	12.1	4.75
Burgess Square Health Care Centre	30	46%	54%	0%	0%	3%	0%	10%	77%	10%	70%	23%	7%	12.2	2.00
DuPage Convalescent Center	45	70%	15%	2%	13%	0%	20%	2%	76%	2%	100%	0%	0%	13.1	3.65
Lake Bluff Health Care Centre	7	71%	29%	0%	0%	0%	50%	0%	50%	0%	71%	29%	0%	13.0	2.81
Northwest Home for the Aged	30	13%	63%	3%	21%	13%	17%	7%	63%	0%	50%	37%	13%	12.3	6.18
Norwood Park Home	37	78%	3%	3%	16%	3%	11%	19%	54%	14%	54%	32%	14%	12.2	4.96
St. Joseph's Home for the Elderly	25	84%	12%	0%	4%	12%	48%	4%	24%	12%	30%	44%	26%	13.0	5.24
Sunset United Methodist Home	8	88%	12%	0%	0%	0%	13%	50%	37%	0%	25%	75%	0%	13.0	4.72

B. IV. EMPLOYEE SATISFACTION WITH THE NURSING HOME: PERCENT OF RESPONDENTS EXPRESSING SATISFACTION

	Total respondents	Very satisfied	Satisfied	Disatisfied	Very dissatisfied
Apostolic Christian Restmor	34	70%	30%	0%	0%
Burgess Square Health Care Centre	30	44%	49%	7%	0%
DuPage Convalescent Center	45	43%	55%	2%	0%
Lake Bluff Health Care Centre	7	86%	0%	14%	0%
Northwest Home for the Aged	30	36%	60%	3%	0%
Norwood Park Home	37	36%	59%	5%	0%
St. Joseph's Home for the Elderly	25	68%	32%	0%	0%
Sunset United Methodist Home	8	25%	50%	25%	0%

B. III. Other Characteristics of the Respondents in the Eight Nursing Homes

Taken together, our respondents at the seven nursing homes also had the following characteristics.

1. 97 percent of them were women, 3 percent were men.

2. 80 percent of them were full time employees, 20 percent were part-timers.

3. 2 percent had only an eighth grade education or less; 12 percent had not completed high school; another 25 percent had only finished high school. 63 percent of the entire group had more than twelve years of schooling; of these 4 percent had completed 16 or more years of schooling.

4. The average respondent had worked 6.5 years in nursing homes. About 1 in 3 of them had not worked in any other nursing home; 1 in 4 had worked in one other; 1 in 5 in two others; and 1 in 6 in three or more others.

B. V. IDPA's QUIP ASSESSMENT SCORE
ON SELECTED ITEMS AT THE EIGHT NURSING HOMES: SUMMER 1986

	Resident Participation and Choice		Resident Satisfaction	Care Plan Goals
	Level	Quality		
QUIP Standard	70.00%	70.00%	70.00%	70.00%
Apostolic Christian Restmor	85.00%	92.00%	91.00%	82.00%
Burgess Square Health Care Center	93.82%	97.14%	80.00%	71.40%
DuPage Convalescent Center	94.65%	98.70%	86.62%	76.80%
Lake Bluff Health Care Centre*	69.60%	78.46%	72.85%	65.10%
Northwest Home for the Aged	94.11%	96.66%	84.61%	77.00%
Norwood Park Home	96.22%	96.00%	84.50%	70.00%
St. Joseph's Home for the Elderly	99.15%	92.00%	96.25%	72.00%
Sunset Methodist Home	96.75%	100.00%	95.00%	74.00%

* Lake Bluff scores are from the January 1986 QUIP survey, when QUIP standards were set at 65% for the four categories. The summer 1986 QUIP survey was incomplete at the time of this writing.